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103D CONGRESS }
2d Session

SENATE

{ REPORT
103-317

HEALTH SECURITY ACT

REPORT

OF THE

COMMITTEE ON LABOR AND
HUMAN RESOURCES

together with

ADDITIONAL AND MINORITY VIEWS

TO ACCOMPANY

S. 2296



JULY 19 (legislative day, JULY 11), 1994.—Ordered to be printed

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Mr. KENNEDY, from the Committee on Labor and Human Resources, submitted the following

REPORT

together with

ADDITIONAL AND MINORITY VIEWS

[To accompany S. 2296]

The Committee on Labor and Human Resources, having considered an original bill to guarantee affordable care coverage for all Americans, to reduce health care costs, to provide long-term home and personal assistance services for senior citizens, and younger Americans with disabilities, and for other purposes, reports favorably thereon and recommends that the bill for pass.

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I. SUMMARY: THE HEALTH SECURITY ACT

The reported legislation achieves the fundamental goals of health reform:

Health insurance for all Americans by January 1, 1998;

Significant cost containment and long-term savings in private and public spending on health care;

Fairly shared responsibility for financing among individuals, employers, and Federal, State, and local governments;

Comprehensive coverage for quality health care with emphasis on preventive care;

Additional support for medical research and teaching;

Additional support for public health activities to make health care more accessible to more Americans; and

Provision of long-term home care and personal assistance for senior citizens and younger people with disabilities;

The bill guarantees all Americans affordable, comprehensive coverage by building on and reforming the system of private, employment-based insurance that protects most people today. It controls costs through a program of managed competition with back-up premium limits. It is financed almost entirely by savings within the current savings, rather than broad-based new taxes. It goes beyond insurance and cost control to tackle a number of important additional needs, including medical liability reform, administrative standardization and simplification, expansion of public health and prevention programs, and improvement of services to vulnerable populations.

By January 1, 1998, every American will have a health security card guaranteeing affordable health care that can never be taken away. The universal coverage portion of the bill is phased-in by States. All States must participate in the program no later than January 1, 1998. States will be allowed to participate in the program beginning January 1, 1996.

PROVISION OF GUARANTEED INSURANCE

The act, as reported, expands the choice of insurance options available and removes the most serious barriers to coverage. Most individuals and employers purchase community-rated coverage in health care coverage areas defined by the State government. Within these coverage areas, they obtain health insurance in one of the following three ways. They may choose to purchase insurance directly from private insurance companies and local insurance agents, as most individuals and employers do today. They may participate in private consumer health-purchasing cooperatives that States will be required to certify to enable individuals and businesses to join together to reduce administrative costs, expand choices, and, in certain circumstances, bargain with health providers. Or they may enroll in the Federal Employees Health Benefits Program, which will be opened to most Americans. This program, which now offers good coverage and wide choice of health plans to Members of Congress, the President, and all Federal employees, will be modified so that all plans offer the standard, comprehensive coverage required under the act. The availability of at least one plan offering freedom of choice of a provider will be guaranteed.

Individuals working for very large companies (1,000 or more employees) obtain insurance through their employer, and it is not community-rated among employers. The employer must offer a choice of a least three plans, and at least one plan must provide free choice of a doctor and hospital. At the option of the employer,

firms of 500 to 1,000 employees may join a community-rated pool, or else purchase insurance outside the pool. Firms not purchasing community-rated coverage may also join together with other larger businesses in voluntary purchasing cooperatives to bring bargaining power to the health care market. Approximately 36 percent of workers are employed by firms with more than 1,000 employees and will be outside the community-rated pool.

People over 65 and the disabled continue to receive coverage through Medicare, although Medicare coverage will be secondary for those over 65 who continue to work—as it generally is today. People currently covered by the Medicaid program join a private insurance plan offered in the community-rated pools.

COOPERATIVES

FEHBP will function as a cooperative in each health care coverage area. States may certify one or more additional cooperatives in each area. If they choose to allow only one additional cooperative, it would be allowed to bargain with plans and exclude those that do not offer a low enough price or high enough quality. In all States, regardless of the arrangements a State makes with regard to cooperatives, individuals and businesses would still have the option of buying directly from insurance companies or through the FEHBP. Plans would not be allowed to undersell a cooperative or FEHBP in the outside market.

HEALTH PLANS

All health plans must offer the standard, guaranteed benefits package. All plans are prohibited from excluding individuals on the basis of pre-existing conditions or refusing to cover such conditions on the same basis as other illnesses. Plans must also have a fair grievance procedure, provide required information to the State and consumers, and meet standards for fiscal soundness and fair marketing practices. All community-rated plans must offer open enrollment to all individuals in the region. No one can be denied coverage, dropped from coverage, or charged a higher price because of poor health.

Plans also have to assure the availability of a sufficient number and type of providers to provide the covered benefits, and they must have arrangements with specialized care centers to guarantee high quality care for individuals with special needs.

Community-rated plans must be certified by the State before they can be offered. In order to be certified, they must meet minimum standards, including standards of financial soundness and abide by all the requirements of the act.

GUARANTEED BENEFITS

The bill includes a comprehensive set of benefits comparable to what most businesses offer today.

The benefits include: hospital services, emergency services, services of physicians and other health professionals, clinical preventive services, mental health and substance abuse services, family planning services, services for pregnant women, hospice, home health, extended nursing care services, lab and diagnostic services, pre-

scription drugs, rehabilitation services, durable medical equipment, prosthetic and orthotic devices, patient care associated with clinical trials, vision and hearing care, preventive dental services for children, and hearing aids for children.

Optional services include health education classes and extracontractual services. In the few areas where the coverage is limited (mental health and substance abuse, restorative dental and adult dental), additional coverage would be phased in by 2001. The National Health Board may recommend changes in the benefit package to Congress and will periodically update the schedule of preventive benefits, to assure the most current scientific knowledge.

The bill allows coverage for the services of all nonphysician providers operating within their scope of practice by defining coverage as being for professional services, rather than physician services. The bill also limits the ability of States to inappropriately restrict the scope of practice of nonphysician providers.

Health plans must offer one of three types of cost sharing: low cost sharing (HMO-style coverage), high cost sharing (fee-for-service style), or a combination plan which offers low cost sharing if a patient uses a select list of providers or higher cost sharing to use other providers. These plans are standardized to ensure simplicity in choosing among plans.

The program puts a heavy emphasis on preventive care. In all plans, there is no cost sharing for preventive services including well baby care and prenatal care. All plans have a maximum out-of-pocket limit of \$2,500 per individual or \$3,000 per family.

SHARED RESPONSIBILITY

The act, as reported by the committee, reaffirms that the cost of coverage will be fairly shared by individuals, employers, and the Government. The existing employer-based structure for purchasing health insurance will be preserved and improved. Employers other than "mom and pop" small businesses will be required to contribute 80 percent of the cost of an average-priced plan, and individuals will contribute the remainder of the cost of the plan chosen, subject to discounts described below. (In practice, in the case of family coverage, any given employer will actually contribute an average of only about 55 percent of the cost; because of the large number of two-worker families, two employers will split the employer's share of the cost.) Employers are free to contribute more than the minimum. Individuals are required to enroll with a health plan and make the appropriate premium contribution to that plan. This is sometimes referred to as an "individual mandate." This is analogous to compulsory participation in Social Security and Medicare.

Small, low-wage "mom and pop" businesses will be exempt from the employer mandate. Small businesses with ten or fewer employees and average wages of less than \$24,000 per worker will not be required to provide health insurance for their employees. Consistent with the principle of shared responsibility, however, firms of five or fewer will be required to contribute 1 percent of payroll toward the cost of the program, and firms of 6 to 10 employees will contribute 2 percent. Employees of such firms will still be required to purchase insurance and they will be eligible for income-related

discounts. For a minimum wage worker, the 1 percent of payroll contribution would be less than 25 cents a day.

DISCOUNTS

To assure that coverage is affordable for both individuals and businesses, the bill provides subsidies for both low-income individuals and businesses employing low wage workers. Greater subsidies are provided for small businesses employing low wage workers. Subsidies are in the form of a reduction in the premium obligation, rather than in the form of a direct payment from government to individuals or businesses.

Targeted subsidies will be available to employers. The subsidies will be based on the relationship between health insurance costs and the wages of the individual worker. No employer's share will be more than 12 percent of an employee's wage. For employers with fewer than 75 workers, the employer's share will be capped on a sliding scale from 4.2 percent to 12 percent of each employee's wage, based on the size of the firm and the average payroll. In each case, the employer will pay no more than the 90 percent share or the amount determined by the percent of wage cap, whichever is less.

The cost of insurance for all workers in nonexempt firms will be capped at 3.9 percent of income. Workers' contributions in exempt firms will be capped on a sliding scale of 4 to 6 percent of income. Non-workers will receive subsidies based on income.

Subsidies will also be available for employers who offer workplace wellness programs. Employees will share the benefit of such programs through reduced premiums.

COST CONTROL: MANAGED COMPETITION AND FALL-BACK PREMIUM LIMITS

Managed competition is designed to reduce health costs by bringing market forces to bear in the health care sector. Individuals are given the incentive and opportunity to choose cost-effective health plans. The effect of providing these incentives to individuals is to put pressure on health plans to deliver care less expensively and will result in more individual enrolling with the most efficient plans—driving national expenditures down. Some proponents of managed competition also emphasize the desirability of many individual purchasers banding together to increase their bargaining power with health plans.

The Health Security Act incorporates the key features of managed competition. Employers make a level contribution to any plan chosen by the individual. Individuals must therefore pay more for more expensive plans and less for less expensive plans. Individuals choosing a plan with a premium lower than the employer contribution receive a cash rebate. To make it easier for individuals to compare plans solely on the basis of price and quality, benefits are standardized and additional information is provided to consumers.

To the concept of managed competition, the bill adds the idea of enforceable, fall-back premium targets. The National Health Board establishes a base per capita premium target for each health care coverage area, based on historical spending and other factors. These premium targets then increase at levels specified in the act.

If competition is not able to hold average premiums to the target level in an area, mandatory limits apply. Plans that are above the target level are required to reduce their premiums enough so that the average premium for the area is at or below the target. Premium limits apply only in areas where competition has not effectively controlled costs and for only as long as competition remains ineffective in these areas. Even if mandatory premium limits apply in an area, plans continue to have incentives to compete to provide quality care at the lowest possible price.

If both these measures should prove inadequate, the National Health Board will review the scope of the mandatory benefit package and recommend revisions that will become effective if the Congress does not reject the recommendations on an expedited basis.

FINANCING

The basic source of financing under the program is the same as it is today—premiums paid to private insurance companies by businesses and individuals. The main cost to the Federal Government of financing universal coverage is the cost of discounts to businesses and low and moderate income individuals. These discounts are financed primarily from savings in existing government health programs, with some additional revenues from the increased cigarette tax and other sources.

As reported by the committee, the bill is designed to eliminate the \$74 billion increase in the Federal deficit projected by the Congressional Budget Office for the President's plan over the first 5 years, and provide additional long-term savings to reduce the Federal deficit.

Additional savings are achieved by the following steps:

Basing employer subsidies in the wages of individual workers, rather than the average wages of the firm, which targets subsidies more effectively on low-wage workers.

Expanding the number of firms permitted to offer coverage outside the community-rated pool by lowering the threshold from 5,000 to 1,000 employees. These additional firms will become subject to the 1 percent payroll assessment in the Health Security Act. Firms of 500 to 1,000 employees will have the option of providing coverage outside the community-rated pool those that do so will pay the 1 percent payroll assessment.

Creating a new self-financing long term care program that will reduce Federal costs for nursing home care.

Providing modest increases in cost-sharing, with additional protection for low-income individuals.

Providing that States share 25 percent of their savings under the act by contributing this amount to the cost of subsidies for individuals and businesses within the State.

Increasing the cigarette tax by 75 cents per pack above the Health Security Act. The current tax is 24 cents a pack. The President's plan would increase it to 99 cents a pack. The committee bill would increase it to \$1.74 a pack. (Since such taxes are in the jurisdiction of the Senate Finance Committee, the provision in the Labor and Human Resources Committee bill is a "sense of the Senate" recommendation.)

LONG-TERM CARE

A new long-term care program will provide home and community-based services to senior citizens and other persons with disabilities. Benefits must include personal assistance services pursuant to individualized plans of care developed by a care manager. Personal assistance services include "consumer-directed" services that are provided by individuals hired, trained, and directed by the person receiving the service. Beyond these requirements, the States have flexibility as to what services will be provided.

The bill also creates a new national program for nursing home insurance to complement the home care program. Individuals age 35 or older may elect to purchase \$30,000, \$60,000, or \$90,000 of insurance protection against the high cost of nursing home care. The policy also provides asset protection in the same amount as the insurance coverage. Individuals purchasing a \$30,000 policy, for example, would have coverage for \$30,000 of nursing home costs. Once the \$30,000 was used up, policy holders would spend their own savings, until \$30,000 of savings was left. The policy holder could then qualify for Medicaid without further "spending-down" their life savings. Individuals may enroll at 10 year intervals beginning at age 35, regardless of preexisting conditions such as Alzheimer's or Parkinson's disease. Premiums are adjusted for age, so that the earlier an individual purchases a policy, the lower the premium. The program will be voluntary, and will be financed by participants' premiums. There will be no cost to the Government (and modest savings to the Medicaid program).

Federal private long term care insurance standards would be established by the National Association of Insurance Commissions (subject to approval by the Secretary.) States would implement and enforce the LTC insurance standards which include mandatory nonforfeiture, mandatory limits on agent compensation and mandatory offer of inflation protection. These standards track those established for the Medigap industry by the Congress in 1990.

INFRASTRUCTURE SUPPORT: ACADEMIC HEALTH CENTERS, PERSONNEL TRAINING, BIOMEDICAL RESEARCH, AND PUBLIC HEALTH

A health insurance card alone is not sufficient to assure quality health care for all citizens. The bill includes provisions to assure adequate support for academic health centers and teaching hospitals, reorient and improve health personnel training, enhance funding for biomedical and health services research, preserve and improve access for underserved populations, and increase investments in public health.

Support for academic health centers, teaching hospitals, and residency training is provided through two programs. The graduate medical education program provides support for the direct cost of approved residency training programs. The academic health centers program provides an add-on to the payments of private payers to reflect the additional indirect costs that academic health centers and other teaching hospitals assume to support medical education, clinical research, and maintenance of the most advanced tertiary care programs. These funds are meant to replace current financing by Medicare and the private sector for these purposes. The bill also

provides support for undergraduate training in medical schools and for graduate nurse training.

To reorient training toward primary care and assure an appropriate supply of specialists, the bill establishes a National Council on Graduate Medical Education to determine national needs for specialty training and reduce the total number of physicians being trained. One goal of the National Council is for 55 percent of physicians in residency programs to be trained in primary health care specialties. If targets are not met voluntarily, the Council may allocate training slots among programs. Enhanced support for graduate nurse training will also improve the supply of personnel able to provide cost-effective primary care. The bill also provides funds for retraining and upgrading of health care workers, so that their skills will be adapted to the changing demands of the health care industry.

To take advantage of opportunities for breakthroughs in the understanding and treatment of disease and to maintain America's world leadership in research and medicine, funding for biomedical research is also increased each year by an amount (phased in) to ultimately equal 1 percent of private premiums—a total of approximately \$10 billion over 5 years. Substantial additional funds are also provided for health services research, outcomes research, and development of practice guidelines.

The bill includes substantially expanded investment in health infrastructure for underserved areas, such as community health centers and the National Health Service Corps and provides funding for "enabling services" to help populations that need special assistance to actually receive services. Preference for funding will be given to organizations currently serving these needs. Funds will also be provided to organizations serving the poor to provide supplemental services not fully covered under the President's plan, such as mental health and substance abuse during the early years of the program, and adult dental care. In addition, all plans are required to contract with essential community providers serving the poor and populations with special needs, to help assure that access to services is available to these historically underserved groups.

The bill provides special support for hospitals serving vulnerable populations, to reflect the additional costs associated with serving the poor and other special needs populations.

PUBLIC HEALTH

The bill creates a new grant program to strengthen the capacity of State and local public health agencies to carry out public health functions such as monitoring and protecting the health of communities against communicable disease, exposure to toxins, occupational hazards, harmful products, and poor quality health care; identifying and controlling outbreaks of infectious diseases, chronic diseases, and injuries; informing and educating consumers and providers about preventing injuries and disease and the appropriate use of medical services; developing and testing new prevention strategies; integrating and coordinating the prevention programs of health plans, community-based providers, local and State health departments, and other related programs; and, conducting research

on the effectiveness and cost-effectiveness of public health programs.

The bill establishes a single application and uniform reporting system for certain public health grants administered by the Centers for Disease Control and Prevention (CDC). The bill provides grants to agencies of State or local government, private nonprofit organizations (including research institutions), and coalitions to develop and implement innovative, community-based strategies in health promotion and disease prevention. The projects will reflect approaches that take into account the special needs and concerns of the affected populations; target the most needy and vulnerable population groups and geographic areas of the Nation; examine links between various preventable health problems; and, establish or strengthen links between public health agencies and health plans, health care providers, and others as appropriate. Special consideration will be given to those projects with potential for replication in other communities, that reduce the prevalence of chronic diseases, that prevent violence against women, and that establish community health advisor programs, and that support the development of rural telemedicine projects.

QUALITY

This bill establishes an independent council of experts, providers, and consumers to assist the National Health Board on quality issues and oversee a performance based program of quality improvement designed to enhance the quality, appropriateness, and effectiveness of health care services and access to care for all Americans. This Council will coordinate with regional Quality Improvement Foundations working with health plans and providers to improve the quality of care based on the latest research and methods.

Today, consumers have little information on the comparable quality of health plans and providers and the information they do have is often confusing. To help consumers select health plans, the National Quality Council will oversee the development of a consumer-friendly report card to convey information on the quality of health plans. Measures of quality of care will specifically look at care for the population at large and for subgroups that may be vulnerable to being underserved or inappropriately served. To the extent that a plan fails to meet quality standards, the State will apply an appropriate corrective measure, ranging from corrective action plans to fines to decertification.

STATE RESPONSIBILITIES

States are given primary responsibility for the implementation of the bill, including certification and oversight of health plans and administration of the discount program. Each State must implement this act through a State plan approved by the National Health Board no later than January 1, 1998. Any State may opt for a single-payer system as long as it meets the requirements of the National Health Board.

MALPRACTICE REFORM

The bill contains a series of sensible medical malpractice reforms similar to those proposed by the Clinton administration. These reforms include mandatory alternative dispute resolution before litigation; limits on attorney contingency fees; collateral source reform; and periodic payment of future damages. Also, the committee authorizes Federal grants to States to determine the effectiveness of alternative approaches such as enterprise liability, no-fault liability, and the use of practice guidelines in malpractice actions.

FRAUD AND ABUSE

The bill establishes a comprehensive program to combat fraud and abuse.

INTERIM INSURANCE REFORMS

Interim insurance reforms would go into effect as soon as the law is passed to prevent plans from price gouging or dumping enrollees. States are responsible for enforcing the reforms, and HHS is authorized to step in where States fail to do so. Plans are required to renew coverage to all currently insured groups and individuals. Plans are required to extend coverage to new full-time employees of presently insured groups and their dependents. In addition, premium increases beyond a specified level must be approved in advance by the State insurance commissioner. Finally, carriers must assess the same premium increase across all policies within each segment of the market—that is, within their individual, small group and large group markets. A special provision of the interim controls gives wider latitude to States that are currently implementing insurance market reforms.

II. HISTORY OF THE LEGISLATION

Senator Kennedy introduced S. 1779 on November 22, 1993, reflecting those portions of the Health Security Act as introduced by President Clinton within the jurisdiction of the committee on Labor and Human Resources. Since the bill was placed directly on the Senate calendar, the committee formally considered an original bill introduced by Chairman Kennedy. The Committee on Labor and Human Resources convened 46 hearings on various aspects of comprehensive health reform and the Health Security Act (38 in 1993, 8 in 1994). The committee also sponsored a New England Health Care Summit featuring First Lady Hillary Rodham Clinton. Some 23 of these 47 hearings were field hearings held in the districts of various committee members to solicit the input of citizens affected by the health care crisis across the United States.

HEALTH REFORM HEARINGS

May 13, 1993	Health Care Reform: Coverage for Mental and Addictive Disorders.
May 20	Comprehensive Health Care Reform: The Need for Action.
September 29	Health Security Act: Hillary Rodham Clinton Testifies.
September 30	Health Security Act: Health Security and Savings.
October 2	Field Hearing: Health Security Act of 1993: Massachusetts Perspective I (Boston, MA).
October 2-3	Field Hearing: Making Health Care Reform Work for all Iowans: A Series of Town Meetings—Sioux City, Des Moines, Eldridge, and Cedar Rapids, IA.

HEALTH REFORM HEARINGS—Continued

October 5	Health Security Act of 1993: View of Health Care Providers.
October 6	Prevention and the Health Security Act of 1993: Investment in Good Health.
October 8	Field Hearing: Accesses to Coverage Under the Health Security Act—Chicago, IL.
October 8	Field Hearing: Health Care Reform Forum—Albuquerque, NM.
October 9–10	Field Hearing: Making Health Care Reform Work for all Iowans: A Series of Town Meetings—Mason City, Ottumwa, Waterloo, and Council Bluffs, IA.
October 12	Field Hearing: Town Hall on Wheels—Baltimore County, MD.
October 12	Field Hearing: Older Citizens Under the Health Security Act of 1993—Pennsylvania Perspective—Pittsburgh, PA.
October 15	Health Security Act of 1993: American Businesses and Workers Respond.
October 16	Field Hearing: Access to Health Care in Rural America: The Need for Reform—Cartersville, IL.
October 16	Field Hearing: The Health Security Act: Impact on Working Families—Pennsylvania Perspective—Homestead, PA.
October 16	Field Hearing: Health Care Reform Forum—Hobbs, NM.
October 18	Field Hearing: Health Security Act of 1993: Massachusetts Perspective II—Fall River, MA.
October 19	Economic Impact of the Health Security Act of 1993.
October 20	Health Alliances: Building a Structure for the Health Security Act.
October 25	Field Hearing: Health Security Act of 1993: Massachusetts Perspective III—Springfield, MA.
October 30	Health Care Reform Forum—Silver City & Las Cruces, NM.
November 1	Field Hearing: Health Security Act of 1993: Massachusetts Perspective IV—Worcester, MA.
November 6	Health Care Reform Forum—Santa Fe, NM.
November 8	Field Hearing: Health Security Act of 1993; Massachusetts Perspective IV—Lawrence, MA.
November 8	Mental Health and Substance Abuse Under the Health Security Act of 1993.
November 9	The Role of the Insurance Industry.
November 10	Long Term Care: Security for Senior Citizens and Individuals with disabilities.
November 12	Roundtable Discussion: The Impact of Health Care—Baltimore, MD.
November 13	The Meaning of Health Care Reform to States and Providers—Springfield IL.
November 15	Field Hearing: Comprehensive Health Care Reform: Consumer Protection Issues—Pennsylvania Perspective—W. Philadelphia, PA.
November 16	Meeting Maternal and Child Health Needs Under the Health Security Act.
November 17	Public Health: Meeting the Health Care Needs of All Americans.
November 18	The Health Security Act of 1993 and the Needs of Rural America.
November 18	The Health Security Act and the Role of the Pharmaceutical Industry.
November 29	Field Hearing: Health Security Act of 1993. New England Perspective—Brattleboro, VT.
December 2	Field Hearing: Rural Health and the Health Security Act of 1993—Carlisle, PA.
December 7	New England Health Care Summit—Boston, MA.
December 8	Health Care Reform and Medical Research.
January 26, 1994	Health Security Act: Training of Health Personnel.
January 31	Field Hearing: The Link Between Health Care Reform and Welfare—Philadelphia, PA.
February 2	Health Security Act: Role of the States.
February 4	Health Security Act: Guaranteed Benefits.
February 22	Health Security Act: Needs of Americans with Disabilities.
March 2	Health Security Act: Early Retirees.
March 8	Mental Health and Substance Abuse under Health Reform.
March 10	Health Security Act: ERISA Preemption of State Prevailing Wage Laws.

The Chairman's mark of the Health Security Act was released on May 9, 1994. The mark-up of the Health Security Act spanned 8

legislative days, beginning on Wednesday, May 18 and reconvening on May 19, 24, 25, 26, and June 7, 8, and 9. The committee ordered the legislation reported out on June 9, 1994, by a vote of 11 to 6. That final vote was tallied as follows:

Aye	Nay
Kennedy	Kassebaum
Pell	Coats
Metzenbaum	Gregg
Dodd	Thurmond
Simon	Hatch
Harkin	Durenberger
Mikulski	
Bingaman	
Wofford	
Wellstone	
Jeffords	

III. BACKGROUND AND NEED FOR LEGISLATION

OVERVIEW

The United States is the only major industrial nation in the world, apart from South Africa, that has no program to guarantee affordable health insurance for all of its citizens. Thirty-nine million Americans—more than 1 out of every six Americans under 65 lack even the most basic coverage. Those Americans who do have health insurance today cannot be certain that it will be there to protect them tomorrow. Over half of all Americans say they worry that they might lose their health insurance at some point in the next 5 years.

Not only does the current health insurance system fail to provide real security, but it is also extraordinarily expensive. The United States spends more on health care on a per capita and an aggregate basis than any other nation in the world. Health care costs are soaring at a rate that threatens to price care out of reach for the ordinary family, place excessive burdens on our economy, and make it difficult for American businesses to compete in international markets. Between 1965 and 1980, national health expenditures grew by almost 500 percent, from \$42 billion per year to \$250 billion per year. By 1993, national health spending had ballooned to \$900 billion. Health spending amounted to only 5.9 percent of gross domestic product (GDP) in 1965, but it totaled 14.3 percent of last year's GDP. And in the next 10 years, health costs will more than double without reform, reaching a total of \$2.1 trillion—20.2 percent of GDP.

LACK OF DEPENDABLE HEALTH INSURANCE

No American can be sure that the health insurance he or she has today will be there tomorrow. A job change, a layoff, rising premiums, or exclusions for certain medical conditions can all lead to a loss of insurance. Every minute, 46 Americans lose their health insurance—2 million a month, 24 million a year. As a result, an estimated 39 million individuals had neither public nor private health insurance coverage on any given day in 1993.

But this figure represents only the tip of the iceberg. In fact, over time a much larger number of citizens are affected by the health insurance crisis. Fifty-eight million people will be without coverage at some point this year. Another study found that 81 million Americans have health conditions that could result in denial of coverage or marked-up premiums if they had to seek a new insurance policy. These trends can be expected to worsen over time if costs continue to rise unchecked.

Some may assume that only nonworking, low- to moderate-income persons lack health insurance. But that is far from the truth. The health insurance crisis is largely a middle-class problem. Working adults and their dependents constitute the vast majority—84 percent—of the uninsured population under age 65. Forty percent of the uninsured are from households with incomes at least twice the poverty level.

In addition to the uninsured, many more Americans are underinsured. According to a survey of more than 1,600 households published in the March 1994, *Journal of the American Medical Association*, 1 in 5 families reported problems paying medical bills. Three-quarters of the families struggling with these costs were insured.

Many workers have had to limit their employment choices to hold on to the coverage they have. In a 1991 *Washington Post/CBS News* survey, one-quarter of Americans said they had stayed in a job that they would have liked to leave because of fear of loss of health insurance benefits. Another study by CBS and the *New York Times* found that a similar percentage had chosen one job rather than another because of health benefits. This phenomenon is not just a health policy problem; by limiting worker mobility, it has a negative impact on the nation's economic growth and efficiency.

Meanwhile, more and more employees are finding that their employers are reducing health benefits. CBS and the *New York Times* also reported that almost half of working Americans said that their employer had cut back on coverage, required employees to pay more, or dropped coverage altogether.

Employers are also reducing the range of health plan choices they offer employees. For example, in 1988, 9 out of 10 employers offered a fee-for-service plan to their workers. By 1992, only 6 out of 10 employers offered this option. Overall, only half of American workers have a choice of health plans.

THE DECLINE IN HEALTH INSURANCE COVERAGE

The number of uninsured Americans has been growing steadily for many years. An analysis by the Congressional Budget Office of trends in health insurance coverage found that in 1978, 23 million Americans did not have health insurance. By 1982, the number of uninsured had risen to 27 million. By 1986, it had climbed to 31 million, and today the number has reached 39 million—an increase of 70 percent. Last year saw the largest increase in the number of uninsured ever recorded.

Growth in the uninsured population may have occurred for several reasons. First, although the proportion of the population in the work force has been climbing, the percentage of workers receiving

health benefits has been dropping. For example, between 1979 and 1993, the percentage of workers receiving coverage through their employer declined from 66 percent to 61 percent. Private sector employer coverage has fallen even further—to 58 percent. This may be partially due to shifts in employment. Many of the new jobs created in the 1980s were in services and retail trade, sectors that have relatively low rates of coverage. Between 1979 and 1985, for instance, the percentage of workers in manufacturing declined from 23 percent to 19 percent, while the percentage of workers in services grew from 28 percent to 31 percent.

Another reason is that the proportion of Americans receiving coverage through another family member's employment has been dropping. Several factors have contributed to this decline. As coverage of primary workers has dropped, so too has coverage of their dependents. This reflects, in part, a decline in employer contributions to the cost of dependent coverage. In 1980, 72 percent of medium- and large-size firms paid the full costs of coverage for their workers, and 51 percent paid the full cost of dependent coverage. By 1991, fully paid individual coverage was available in only 45 percent of firms, and fully paid family coverage in 23 percent.

One major reason for the failure of employer-sponsored coverage to keep pace with the increased number of workers and their families is the rising cost of health benefits. Rising health care costs present a particularly serious problem for small businesses, which, as discussed below, face special problems in obtaining health insurance for their workers. If health insurance premiums continue to climb faster than either prices in general or prices for medical care, as they have over the last decade, many firms may decide to forego health insurance entirely, adding to the ranks of the uninsured.

While private insurance coverage has been falling, the public sector has taken on additional burdens. Between 1989 and 1992, Medicaid coverage increased from 21.1 to 28.5 million people. But even this large increase was not enough to compensate for the accelerating decline in private sector coverage.

CONSEQUENCES OF BEING UNINSURED

Not surprisingly, uninsured individuals are generally in poorer health than the insured. A study in the early 1980's sponsored by the Robert Wood Johnson Foundation found that about 15 million Americans every year are turned away when they ask for health care or do not even seek care they need, because they know they cannot afford it. Because they lack coverage for routine care that could detect and cure health problems before they become serious, uninsured individuals generally receive medical help when a condition is much more advanced.

According to the Office of Technology Assessment, uninsured patients are up to twice as likely as insured patients to be at risk of dying when they reach the hospital door. At that point, their condition often requires expensive treatment as likely as insured patients to require both avoidable hospitalizations and emergency hospital care.

A study in the District of Columbia found that almost half of the uninsured admitted to hospitals, excluding those admitted for delivery of a child or trauma, could have avoided hospitalization if

timely outpatient care had been available. Other studies have found that once hospitalized for care, the uninsured experience poorer medical outcomes than those with insurance, including higher rates of mortality. The uninsured also have less access to high cost technology and to services that involve significant physician discretion, such as diagnostic tests, elective surgery, and different courses of treatment for cancer.

ESCALATING HEALTH CARE COSTS

The United States spends more per capita, and a greater proportion of its gross domestic product (GDP), on medical care than any other industrialized nation. In 1991, per capita health spending in the United States averaged \$2,867, while it was only \$1,035 in the United Kingdom and \$1,915 in Canada. Similarly, the United States spent 13.2 percent of its GDP on health care in 1991, compared with much lower percentages in other countries: 6.6 percent in the United Kingdom, 6.8 percent in Japan, 8.6 percent in Germany, and an average of 7.9 for the 24 countries in the Organization for Economic Cooperation and Development. Moreover, the percentage of GDP devoted to health care has been rising much more quickly in the United States than in other comparable countries. Between 1970 and 1991, health care spending grew from 7.4 percent to 13.2 percent of GDP in the United States, and exceeded 14 percent in 1993. In the next 10 years health expenditures in the United States are projected to more than double without reform, growing to 20.2 percent of GDP.

While some have claimed that health care cost increases have begun to slow, the evidence in support of that position is weak. Last year, the medical care component of the CPI increased twice as fast as general inflation. Even more striking, the increase in medical prices in excess of general inflation (2.8 percent) was actually higher last year than the average for the last two decades (2.5 percent). Moreover, any recent slowdowns may have been behavior in anticipation of health care reform—a pattern that we saw in response to the Carter administration's proposal to cap hospital revenues and to the enactment of the Medicare prospective payment system. In both cases, temporary pauses in spending were followed by renewed acceleration in costs.

Escalating health costs have placed a particularly heavy burden on American families. The amount the average family spends a year on health care almost tripled between 1980 and 1993, jumping from \$1,749 to \$5,190. If current trends continue, total annual spending by the average family on health care will reach \$11,070 by 2000.

Even more troublesome than the increase in absolute costs is the increasing share of family income that health care is absorbing. In 1980, average family health spending amounted to 9 percent of income. By 1993, the share had increased to 13.1 percent, and without reform, the share of family income going to health care will reach nearly 19 percent in the next 10 years. As a result, more and more Americans simply cannot afford to cover all their health needs. An August 1991 Gallup survey reported that 27 percent of respondents said that there had been times in the previous 12

months when they had not had enough money to pay for medical or health care.

The seemingly inexorable rise in health care costs is also putting heavy pressure on the Nation's businesses. Between 1984 and 1991, the average annual health plan cost for employers more than doubled from \$1,645 per employee to \$3,604 per employee. Total business spending on employee health premiums more than quadrupled between 1980 and 1993, from \$57 billion to \$233 billion. By the year 2000, business payments for employee premiums are projected to rise to over \$419 billion, a more than sevenfold increase over two decades.

On survey of medium and large employers reported that the average premium for health benefits for a single employee grew at an average annual rate of 16 percent over the period 1987-91, as health care costs jumped from \$2,000 to \$3,600 per covered employee. The growth occurred despite such cost-containment efforts by businesses as shifting to self-insurance, requiring greater employee cost sharing, and the increasing adoption of techniques to manage the cost of care, such as hospital preadmission certification and discounts for using certain providers.

The unchecked rise in health care costs can have a devastating impact on the bottom line. While health care spending totalled 14 percent of after tax corporate profits in 1965, it totalled more than 100 percent in 1989. As noted by Joseph Califano (former Secretary of the Department of Health, Education and Welfare) in testimony to this committee, this money could have gone to shareholders in the form of higher profits, to workers in the form of higher pay, or to plant modernization, research and development to make industries more competitive. Moreover, as workers seek to maintain adequate insurance protection and businesses increasingly seek to reduce to rise in their own costs, conflict is inevitable. In 1990, health care was the major issue for 55 percent of striking workers.

The escalating cost of employer-sponsored health plans also takes a toll on the ability of American companies to compete on the world market. According to the Department of Labor, health care costs added \$1,100 to the price of every car made in America, double what Japanese manufacturers had to pay per car produced. Analysts have noted that the rising cost of health care also is likely to impair the ability of American electronics, communication, steel and other industries to compete with other industrialized nations.

Finally, excessive inflation in health care costs is the main engine driving the Federal deficit, and it is driving out resources needed to meet every other social need. Between 1993 and 1998, half of all Federal spending growth will be for health care, even though health care only accounts for 19 percent of total Federal spending. The Advisory Council on Social Security estimated that every dollar of economic growth between now and the year 2030 will be eaten up by excess health care cost inflation if current trends continue, leaving nothing left over to improve wages and living standards or to meet pressing social needs like fighting crime or investing in better education.

An analysis of the sources of excessive health care spending suggests that the problem can be solved effectively by comprehensive reform—without harming the quality of care. For example, much of

the high cost of medicine comes from the exploding administrative costs of a system drowning in red tape. Billions of dollars—possibly over \$100 billion—are spent on administrative costs. While some of these costs are unavoidable, some administrative activities have little to do with the actual delivery of health care.

There are two types of excess administrative costs. First, the overhead costs of insurance companies in the small business and individual insurance market are excessive. As much as 40 cents of every dollar that a business with fewer than 10 workers pays in premiums covers sales and administrative costs and profit rather than actual health benefits. By contrast, only 5 cents of the premium dollar paid by a large company goes for insurance company sales and administrative costs and profits. In the Medicare program, the administrative share is only 3 percent.

In addition to excessive costs that directly appear in insurance company balance sheets, the fragmented payment system adds to the costs that health care providers must incur and that are ultimately passed on to patients in the form of higher charges to patients and higher health insurance premiums. Because health insurance is sold by as many as 1,500 different insurance companies, physicians and hospitals must deal with many different insurance forms and billing procedures, adding to overhead costs and making conversion to cost-effective electronic billing difficult.

The multiplicity of payers and the lack of integrated systems of care mean that utilization review activities are often wasteful and poorly targeted. Since few companies have a large enough data base to determine which physicians are not practicing cost-effective care, the careful and wasteful alike must spend an inordinate amount of time, with associated costs, dealing with insurance company reviewers.

Children's National Medical Center in Washington, DC, estimates that it takes 60,000 hours of medical and nursing staff time each year to generate billing and other information required by insurance companies. According to a 1988 survey by the AMA, each doctor spends more than three full workweeks every year filling out insurance claims forms. Six of every 10 jobs in doctors' offices are filled by clerks or administrators. Salaries for administrative staff consumed over 22 percent of the average hospital's payroll costs. And the average hospital increased its administrative staff threefold between 1968 and 1990.

Another source of high costs is unnecessary or even harmful medical care. There is no one standard for high quality medical care in many cases, and a wide range of practices may be accepted for specific conditions. Because the field is changing so rapidly, there is often a significant divergence from the best practice based on the most up-to-date research and the usual practice of many professionals. Some believe that there is a professional norm in modern medicine that leads physicians, when faced with uncertainty, to act rather than wait, or "when in doubt, do." This can often result in unnecessary and inappropriate services.

New technologies, defensive medicine, and financial incentives for providers also contribute to overused services and inappropriate care. Fee-for-service and cost-based reimbursement methodologies

encourage physicians to do more. Fear of malpractice litigation may also encourage physicians to engage in defensive medicine.

Evidence of unnecessary and ineffective health care in the U.S. has become commonplace. For example, analyses that compare the delivery of services across geographic areas have found significant variations in average length of hospital stays, hospital discharge rates, and surgical procedures. One study found that the likelihood that a woman in Maine would have a hysterectomy by the time she reached 70 years of age ranged from a low of 20 percent in one community to a high of 70 percent in another. According to a recent article in the *New England Journal of Medicine*, Medicare payments for doctor's care ranged from a low of \$872 per beneficiary in San Francisco to a high of \$1,874 in Miami, even after adjusting for age and sex. The main difference is practice style, not fee levels, and there is no evidence that care is better in Miami than it is in San Francisco.

These variations generally cannot be explained by differences in the health status of the populations, or standard physician characteristics, such as age, specialty or medical school. The most important factor seems to be differences in the practice styles of physicians. While the resulting care may be appropriate, often it is not. Sometimes the procedure is not superior to alternative treatments in producing net benefits for the patient.

Other studies have determined that common procedures such as angioplasty, coronary artery bypass surgery, cardiac pacemaker implantation, and caesarian section deliveries, are often used without producing any medical benefit for the patient. For example, a RAND Corp. study found that 32 percent of carotid endarterectomies were inappropriate; comparable figures for coronary angiography and upper gastrointestinal endoscopy were each 17 percent. A review of the relevant literature by the GAO found that between 14 and 32 percent of surgical procedures were inappropriate, while 7 to 19 percent of hospital admissions were inappropriate. By some estimates, as much as one-third of all U.S. medical care may be unnecessary or of marginal value.

Unnecessary and inappropriate services are not only a financial burden; often, they also pose a risk to patients. An unnecessary caesarean section can lead to infections, a prolonged hospital stay, and psychological distress for the newborn's mother. Inappropriate use of antibiotics may expose patients to unjustified side effects and lead to the proliferation of organisms that are resistant to antibiotics. Unnecessary open-heart surgery poses a significant risk of death.

Cost-shifting is another source of high costs for those who have insurance and for businesses that do the right thing and insure their workers. In 1990, according to the Prospective Payment Assessment Commission, cost-shifting from all sources added an average mark-up of 30 percent for private insurance. For private patients whose insurance still pays full charges and is unable to obtain discounts, the markup can be much higher—more than 50 percent above costs in many cases. While less data is available for nonhospital providers of care, cost-shifting is believed to be pervasive for all types of health services.

A substantial portion of employer health care spending pays for the costs of uncompensated care for workers at firms that do not offer an employee health plan. In 1991, employers providing health insurance paid \$10.8 billion for uncompensated hospital care, half of it for uninsured employees at other firms. Employers offering employee insurance also paid another \$26.4 billion for dependents employed by other firms that do not provide insurance. In total, employers offering family coverage pay a mark up of between one-quarter and one-third to cover the shortfall from companies that offered employee-only coverage or no coverage at all.

Cost-shifting is not only unfair, it makes overall cost control far more difficult, because the true cost of care is masked. A payer trying to negotiate with a provider has no idea whether low costs represent efficiency or simply a small number of uninsured patients. The reverse is also true. Only universal coverage can clarify the true cost of care and make it possible to bring efficiency to the system as a whole.

Inadequate preventive care is also a source of substantial health care costs—as well as needless pain and suffering, lost years of life, and diminished productivity. Over 260,000 low birthweight babies are born each year, and over 23,000 die. Each low birthweight baby that lives runs up an average neonatal intensive care bill of \$10,000—and some run into the hundreds of thousands of dollars, some even more than a million dollars. Much of these costs and needless deaths could be eliminated by timely prenatal care. According to a study by the Harvard School of Public Health, U.S. employers spend more than \$5.6 billion annually for health care associated with poor birth outcomes. The CDC estimates that for every dollar spent immunizing children against disease, \$10 are saved. For measles, spending \$1 saves \$14. Yet, in a majority of American States, fewer than 60 percent of all pre-schoolers have received appropriate immunizations and the percentage has actually declined in the past 10 years. The American Cancer society estimates that 100,000 lives could be saved annually with proper screening procedures.

Fraud is another source of health care costs. The GAO has estimated that fraud and abuse in the health care system may add as much as \$100 billion a year to system costs.

A root cause of excessive health care cost inflation is the lack of effective market forces in health care. Patients cannot effectively compare cost and quality at the point they need health care. Competition could be effective if health plans competed over price and quality, but the current system puts a premium on selecting healthy people to insure, not on delivering care effectively and efficiently. Plans themselves lack good data on health outcomes and on the relative efficiency of different providers. The lack of a standard benefit package makes it difficult for patients to compare insurance companies based on a level playing field. Employer-paid health insurance is not generally set up in a way that makes employees sensitive to price differences between plans—and employees generally have few plans to choose from, in any event.

SPECIAL PROBLEMS OF SMALL EMPLOYERS

Uninsured workers are disproportionately likely to be employed by small firms. People in firms employing fewer than 10 account for 17 percent of all workers and dependents, but they constitute 30 percent of the uninsured work force. Forty-three percent of all uninsured workers and their dependents are in firms with fewer than 25 employees.

Health care costs are also significantly higher for small businesses than for medium and large firms.

Small employers face some special problems in trying to provide health insurance for their workers. They are often low-wage firms, for whom health insurance coverage may represent a substantial increase in total compensation costs. They are sometimes more economically fragile than large businesses. The root cause of the difficulties faced by small businesses, however, lies in the nature of the private insurance market. Small firms are often unable to buy coverage at any price, must pay more for coverage when they are able to obtain it, and cannot count on stable premiums.

EVOLUTION OF THE PRIVATE INSURANCE MARKET

The private health insurance system has evolved gradually over the course of this century, largely in response to competitive pressures. One important trend has been a gradual move away from cross-subsidization of the costs of health care coverage. In the 1930's, the original Blue Cross plans, along with similar plans developed by providers or consumers of care, offered insurance at standard rates to all purchasers. Under this "community rating system," low-risk individuals and groups subsidized the costs for the higher-risk segments of the insured population.

The rise of competition from commercial insurance companies in the 1940's led to a crucial innovation: "experience rating" for large groups. Low-cost groups demanded that the rates they paid for coverage be related to the costs incurred for their group alone. The commercial insurers met this demand. Ultimately, the Blues were obliged to follow their lead and to offer some form of experience rating to large groups. Some groups found that they had sufficient resources to withdraw from the market altogether and insure themselves, further reducing the pool of firms seeking coverage in the community-rated market. Today, nearly 60 percent of the Nation's employees are enrolled in a plan with some aspect of self-insurance.

In today's small group insurance market, competition among insurers has become largely based on risk selection and not on the basis of efficiency or service to the customer. The logic of a competitive insurance market has thus worked to reduce the degree of cross-subsidy in the cost of health insurance, as insurers compete for the business of the groups presenting the most favorable or predictable risks.

UNDERWRITING AND RELATED PRACTICES FOR SMALL BUSINESS

In considering what employer groups to accept and what premium rates to offer them, insurers consider characteristics of the entire group, such as the type of business in which the firm is en-

gaged, as well as characteristics of individual members of the group that may predict their future need for health services.

Redlining is typical in the small business insurance market. Several characteristics of firms may lead some insurers to deny coverage or to offer coverage only with special restrictions or very high rates. Some groups experience seasonal employment. In this case, medical care utilization often peaks just before layoff, or dependents seek medical care just after the employee goes back to work. Other small employers may be denied coverage because they are in industries that present a high risk of occupational illness or accidents, such as mining, logging, commercial fishing, oil exploration, and explosives manufacturing. Finally, some companies may pose credit risks because they are in a line of business with a high failure rate.

If a firm is not redlined out of coverage because of the nature of its business, it may face an additional barrier to coverage: medical underwriting. Generally for groups of fewer than 25 workers (but sometimes for groups as large as 99), an insurer may require medical information about each employee. If some members of the group are determined to present high risks, the insurer may deny the whole group coverage, offer coverage to the group only if the high risk employees are excluded, or permit the inclusion of these employees but increase rates to the entire group.

Other limitations may apply even if the group is granted coverage. Typically, the policy will exclude coverage for preexisting conditions, problems that were already diagnosed at the time the policy took effect. Although such exclusions are usually time-limited, they in effect deny coverage for the very conditions for which coverage is most needed. The insurer may offer coverage only condition that it might not offer the same policy to the group when the contract expires. If the group turns out to have higher costs than anticipated, the insurer can refuse to renew the coverage.

Finally, insurers may be concerned that, within the approved group, only employees who foresee a need for health care will actually participate in the plan. If this occurs, the higher cost enrollees will not be balanced by lower cost, healthier employees. For this reason, many small group policies require minimum participation levels. In the very smallest groups, the policy may stipulate that 75 to 100 percent of eligible workers must enroll. To achieve these participation levels, employers must limit the share of premiums paid by the employees themselves. Very small employers may be required by the terms of their policies to pay the entire premium.

THE HIGHER COST OF COVERAGE FOR SMALL EMPLOYERS

Small employers who clear the underwriting hurdles and obtain health coverage will generally pay more than larger groups for an equivalent plan. While estimates vary, health insurance premiums for the smallest firms may average 10 to 15 percent more than the premiums charged to larger businesses, and the difference may exceed 35 or 40 percent for equivalent plans.

For the smallest plans (1 to 4 employees), the insurer surcharge to cover administrative, sales and other costs can equal as much as 40 percent of claims. These costs drop to 35 percent for groups of 5 to 9, 30 percent for groups of 10 to 19 and 25 percent for

groups of 20 to 49. By comparison, total administrative expenses of the largest conventionally insured plans (10,000 and more employees) are 5.5 percent of claims. In self-funded plans, which are generally not an option for small employers, administrative costs can be as low as 2.5 percent of claims. In addition, larger plans are more likely to use HMO's, PPO's, and managed care, which can help to reduce the cost of coverage. Smaller employers are not likely to have as much access to such cost containment features.

One factor raising costs for small groups is the commission paid to the insurance agent or broker who sells the policy; this averages 8.4 percent of claims for groups of fewer than 5 enrollees, and less than 1 percent of claims for groups of 500 or more. A second factor is the "risk" or "risk and profit" charge, which includes both the insurer's profits and some cushion against unexpectedly high claims cost. The risk charge averages 8.5 percent for groups of fewer than 5, and drops to 3.5 percent or less for groups of 500 or more.

In addition to administrative charges, two other costs factors are often cited as barriers to the purchase of health coverage by small businesses. The first is the effect of State mandated benefit laws, which require insurers to cover certain types of services or services by certain types of providers, provide for continuation or conversion of group coverage, or mandate coverage of certain individuals such as dependents. As of 1991, the States had enacted close to 1,000 such laws. Larger firms can escape these laws by self-insuring, since self-insured plans are exempt from State regulation under the ERISA statute. Small businesses cannot afford the risk involved in self-insuring.

Another cost factor is the effect of current tax policy on unincorporated small business. The owners of sole proprietorships or partnerships and the major shareholders of S corporations may deduct from their income only 25 percent of the cost of insuring themselves and their families; if the same business were incorporated, the whole cost would be deductible. This means that the after-tax cost of a health plan is higher for self-employed individuals.

In addition to facing higher initial costs for coverage, small employers may find that their premiums increase rapidly after the first year of coverage. If a group is medically underwritten, it may start out with a healthy pool, since the group members with a known, immediate need for health services have been excluded. Over time, however, those left in the pool will gradually use medical care at greater rates. The cost of claims paid under the policy rises. Accordingly, many insurers raise the rates after the first year of the policy. (Some may offer, as an alternative, to reunderwrite the group, again separating the currently sick from the currently healthy). There may also be cases in which insurers quote artificially low rates for the first year in order to gain new business.

Another rating practice that has gained some currency is group-specific rating, especially for years after the initial year of the policy. Pure experience rating, in which premiums are based on actual or the particular group, is still uncommon in the small group market. However, some insurers may classify small employers into broad ranges, or tiers, by claim experience. A group with unexpectedly high costs during a year may be reclassified into a new, higher rate tier.

Employers who present the best risks may respond to annual rate increases by seeking a new insurer who will offer a more affordable first year rate. As a result, while insurers are competing more vigorously for the groups that present more favorable risks, their business may increasingly consist of higher risk groups unable to find a lower price. The frequent switches of plan by small employers that is encouraged by these features is sometimes called churning, and is yet another factor driving up costs, since it is expensive to enroll and disenroll groups.

NEEDS OF WOMEN, CHILDREN, AND MINORITIES

Millions of men and women of all ages, races, and ethnic groups lack access to adequate health care under the present system, but women, children, and members of minority groups are particularly vulnerable.

Women

In 1991, 11.8 million adult women under age 65 had no insurance, and many more who had insurance lacked full coverage for services that are essential to meet their health needs. As a result, many women do not receive adequate care under the present health insurance system.

For example, the percentages of uninsured persons is highest for both sexes between the ages of 18 and 25. Twenty-two percent of women and 29 percent of men in this age are uninsured. But the women in this age group are particularly affected by this lack of insurance, because they generally use medical services much more intensively than men, owing to the need for regular gynecological examinations and prenatal care.

Another problem for many women is that many insurance policies do not provide adequate coverage for preventive services, such as Pap smears and mammograms. Consequently, they do not receive the kind of screening services, such as Pap smears and mammograms, that could detect cervical, ovarian, or breast cancer in their early stages and help to save lives.

Low incomes also pose a significant barrier to adequate health care for many women. According to one study, one-third of all women are either poor or low-income, as compared to 26 percent of men. These women are likely to be uninsured or suffer poor health because of the difficulties they face in paying health costs.¹ Households headed by women are also more likely to lack insurance—18 percent of female-headed households with children are uninsured, compared with 13.5 percent of households with children headed by males or two parents.

Children

Between 1977 and 1987, the number of uninsured American children under age 18 grew by 40 percent. By 1993, 10 million children had no health insurance of any kind. Over a longer period of 28 months between 1987 and 1989, almost 1 out of every 3 children was without health insurance for some time. More than half of

¹Id. at 34-35.

these uninsured children have parents who work full-time, and more than two-thirds are in households headed by two parents.

Studies have shown that this lack of insurance corresponds to a lower level of health care. Uninsured children receive fewer ambulatory care visits, immunizations, and prescription drugs than those with insurance. Uninsured children are also less likely than insured children to have a usual source of care, and when they do it, it is less likely to be a physician's office. As a result, uninsured children have less continuity of care than those with coverage, and many symptoms may simply go untreated. For example, only two-thirds of uninsured children with more than two ear infections in a 12-month period saw a physician, as compared with almost 90 percent of insured children.

The insurance status of pregnant mothers also has a significant impact on children's health status. A 1987 General Accounting Office review of pregnant women who either had no health insurance or were on Medicaid found that 63 percent obtained insufficient prenatal care. Over 12 percent of the babies born to these women were of low birth weight, almost twice the percentage of low birth weight babies nationwide. Sixty-seven percent of infant deaths during the first 4 weeks of life and 50 percent of deaths in the first year of life were attributed to low birth weight. Surviving infants were at increased risk of serious illness or lifelong handicaps. The cost to society of low birthweight infants for 1985 was estimated by the American Academy of Pediatrics to be as high as \$3.3 billion, at an average cost of \$14,698 per infant.

Testifying before this committee, Dr. Reed Tuckson of the March of Dimes reported that over 600,000 uninsured women give birth each year. The prevalence of noncoverage among pregnant women may help to explain why the United States has one of the highest infant mortality rates of the industrialized world—tied for last place among 20 industrialized nations.

Members of Minority Groups

As detailed in an earlier report by this committee, the health status of many minority citizens in the United States lags well behind the rest of the Nation. An African American child is less likely to receive checkups and immunizations and twice as likely to die in the first year of life as a white child. Life expectancy for African Americans is 6 years less than that of whites. Hispanic Americans suffer disproportionately high rates of AIDS, diabetes, and many types of cancer. A large proportion of American Indians die before age 45. The rate of Hepatitis B infection among Southeast Asian Americans is 17 times higher than for white Americans, and the incidence of tuberculosis is 5 times higher among Asian Americans.

These differences can be traced in part to the fact that members of these minority groups are more likely to be uninsured than the white population. One in every three Hispanic Americans and 1 in 5 African Americans are uninsured, as compared with 1 in 8 whites. Despite these substantial disparities, however, the great majority of the uninsured are not minorities.

PUBLIC HEALTH

A strong public health system is necessary to support and enhance the effectiveness of health care reform. Over the last decade, Federal support for the essential activities of public health has decreased relative to total health care expenditures. In 1981, 1.2 percent of all health care dollars were spent on population-based public health programs. By 1993, this proportion had decreased by one quarter, to only 0.9 percent. This decrease in funding has occurred during a time in which the public health system has faced increasingly serious health challenges including the explosion of the AIDS epidemic, alarming increases in violence, and the re-emergence of once declining infectious diseases, such as tuberculosis. The Institute of Medicine recently sounded the alarm on the need to strengthen the public health system in its report *The Future of Public Health*.

Public health has a very strong track record on which to base its position alongside the personal health care system in improving the health and well-being of the American people. Many of the dramatic gains in life expectancy of Americans achieved over the course of this century, from less than 50 years in 1900 to more than 75 years in 1990, are largely due to successes in public health. Improved sanitation, control of infectious disease, better immunizations, and other public health programs have all made significant contributions. The population-based programs launched in the 1970's are largely responsible for the recent improvements in tobacco use, blood pressure control, dietary patterns, automobile safety restraint, and injury control measures that have led to declines of more than 50 percent in stroke deaths, 40 percent in coronary heart disease deaths, and 25 percent in overall death rates for children.

As health care reform is implemented, the public health system must be prepared to play a new and expanded role in a reformed health care environment. With health insurance available to all Americans, the emphasis of public health programs will shift from providing personal health care services to its more traditional role of safeguarding the health of entire populations and communities. Public health is the foundation upon which the entire health care system is built and includes the following essential activities: protecting the environment, work places, housing, food, and water; promoting healthy behaviors; monitoring the health status of the population; mobilizing communities to address health concerns; responding to disasters; assuring the quality and availability of medical care; providing medical services when needed; securing a skilled public health workforce; research new, innovative health strategies; and, developing sound health policy and planning for a healthier future.

LONG-TERM CARE

Virtually all senior citizens have insurance through the Medicare program—and many of the disabled are covered as well. But Medicare has significant gaps. The lack of coverage for prescription drug presents an enormous burden for million of seniors. And long-term

care is truly the unfinished business of Social Security and Medicare.

Long-term care (LTC) is the assistance needed by individuals of any age with chronic impairments so they can carry out the routine activities of daily living (ADLs, such as eating, bathing, dressing, toileting, and transferring from a bed or chair) and instrumental activities of daily living (IADL's, such as prepared meals, cleaning house, or paying bills). It may also include skilled medical or therapeutic care.

There is an enormous need for LTC. Some 12.6 million Americans need help with ADL's or IADL's. More than 4 out of 5 live not in nursing homes, but in their own homes and communities. Of the 10.3 million individuals living in the community who need LTC, some 3.1 million have the most severe disabilities. That is, they require assistance with 3 or more ADL's, they have severe cognitive or mental impairments, or they have mental retardation or developmental disabilities. Of the severely disabled, more than two-thirds (68 percent) are age 65 and over.

Table 1 indicates that types of disabilities among individuals with severe disabilities.

TABLE 1.—ESTIMATES OF PERSONS WITH SEVERE DISABILITIES, BY TYPE OF DISABILITY

Type of disability	Number in thousands	Percent
Severe cognitive or mental impairment	1,250	40.5
Severe or profound MR/DD	270	8.7
3+ADL's	1,570	50.8
Total	3,090	100

The current system for providing LTC is inadequate. Since Medicare does not cover LTC, the vast majority of LTC is currently provided by family and friends—often taking an enormous toll on these individuals. The public funding that is available is fragmented and poorly coordinated.

The primary source of funding for LTC is Medicaid—which is a welfare-based program with a strong institutional bias. Medicaid programs vary widely from State to State and often have stringent caps on the number of individuals they can serve outside of institutions. Yet all State Medicaid programs require individuals to have virtually no assets in order to receive benefits and to pay most of their income to the cost of LTC.

While nearly half of severely disabled individuals have very low incomes, not all low- to moderate-income persons are eligible for Medicaid coverage. Few individuals have incomes high enough to pay for all the LTC services that they need. A substantial proportion of individuals with severe disabilities have incomes too high to be eligible for Medicaid, yet are unable to afford the services they need to remain in the community. Table 2 provides an estimate of the income level, as a percentage of poverty, for persons with severe disabilities.

TABLE 2.—ESTIMATES OF PERSONS WITH SEVERE DISABILITIES, BY INCOME AS A PERCENT OF THE POVERTY LEVEL

Income as a percent of poverty (Dollars for an individual in 1994)	Number in thousands	Percent
Less than 100 percent (less than \$7,360 a year)	977	31.6
100–149 percent (\$7,360–\$11,039 a year)	440	14.2
150–199 percent (\$11,040–14,719 a year)	429	13.9
200–249 percent (\$14,720–18,399 a year)	318	10.3
250–299 percent (\$18,400–22,079 a year)	208	6.7
300–399 percent (\$22,080–29,439 a year)	503	16.3
400–499 percent (\$29,440–36,799 a year)	144	4.7
500 percent or more (\$36,800 or more a year)	72	2.3
Total	3,090	100

There is a clear and pressing need for a national program of home and community-based LTC that is available to individuals regardless of age, type of disability, or income. Given the current constraints on Federal resources, it seemed most reasonable to develop a program that targets LTC services to persons with the most severe disabilities. However, persons with fewer than 3 limitations in ADL's also need LTC services.

While the majority of persons who need LTC prefer to remain in their homes and communities for as long as possible, there is a pervasive fear that the cost of nursing home care will lead to impoverishment. This fear is well based since over two-thirds of individuals in nursing homes have exhausted their life savings and qualify for Medicaid. Currently there are some 2.3 million Americans who reside in nursing homes and, according to studies by the Brookings Institution, between 35 and 50 percent of today's senior citizens will enter a nursing home at some point in their lives.

Long-term care is not just a crisis for persons with disabilities—it is a crisis for their families as well. Few relatives are prepared—either financially or emotionally—to take on the heavy responsibility of providing the care that their loved ones need.

The private LTC insurance market has attempted to provide some protection from the potentially catastrophic costs of LTC, but LTC insurance is not available to the currently disabled due to insurance underwriting and there are many problems with the products and marketing tactics.

These problems include high rates of lapsed policies, abuses by insurance agents, and decline in the value of policy benefits during the long time elapsed between the purchase of a policy and when it is needed.

Too many senior citizens who purchase a policy let it lapse. A recent survey by the Health Insurance Association of America found lapse rates of 12 percent a year. In other words, if a hundred senior citizens buy a long-term care policy at age 65, fewer than two will still have coverage at age 85, when they are most likely to need it.

In addition, agents' commissions are sometimes designed so that up to 70 to 80 percent of their total compensation on a policy is paid up front, at the time of the initial sale. Only 20 to 30 percent is based on policy renewals. The result is to encourage the sale of multiple policies to senior citizens, and discourage the renewal of existing policies. Because of rising costs, policies adequate today are likely to provide only minimal protection when they are needed

in the future. A nursing home stay that now costs an average of \$86 a day will cost \$228 twenty years from now, assuming a modest inflation rate of just 5 percent a year. The most recent GAO study of States' compliance with voluntary standards for inflation protection found that 40 States were not in compliance.

Senior citizens buy long-term care insurance to protect against the worst case—a lengthy stay in a nursing home. Such stays account for the majority of dollars spent on long-term care, and are often needed for Alzheimer's patients. The Alzheimer's Association recently released a study on the inadequacy of even top-of-the-line insurance policies to protect families against the financial devastation of Alzheimer's disease. Long-term care policies must pass the "Alzheimer's test" if families are to receive full value of their long-term care insurance dollar.

In response to similar abuses in so-called "Medigap" policies to protect the elderly against bills not covered by Medicare, Congress passed legislation in 1990 setting basic standards for such policies. Similar legislation is needed now to correct the abuses in private long-term care policies.

Even with improvements in the private long-term care insurance market, there is a need for a voluntary, public long-term care insurance program. Persons who are currently disabled find it impossible to purchase affordable LTC insurance in the private market. Yet such individuals should be able to provide for their future needs, which may include the need for nursing home care.

In addition, given the highly mobile nature of American society, it is critical that a long-term care insurance policy offering Medicaid asset protection be available that is portable to any State in the Nation. As an individual becomes more frail and requires nursing home care, he or she may wish to enter a nursing home in a location that is closer to a child or other family member. At the present time, policies offering Medicaid asset protection that are sold in one State will only provide this protection in that State. Further, private LTC policies offering Medicaid asset protection are available in only 5 States.

The establishment of a public long-term care insurance program will also help to focus public attention on the need for long-term care. Most Americans today are poorly informed as to the possible need for long-term care and optimistically, but erroneously, assume that such need will never pertain to them. As a result, most individuals fail to adequately plan for the possibility of needing long-term care and are dismayed when they realize that the only public coverage for nursing home care is through Medicaid, which requires personal impoverishment.

Finally, a public long-term care insurance program potentially offers the same advantage of very low administrative costs provided by Medicare.

Children represent a small but distinct segment of individuals with disabilities. The medical needs of children with disabilities differ substantially from those of adults; especially, the specificity of pediatric conditions and the impact of prevention and early intervention on life long disabilities and serious medical complications. Certain childhood disorders are commonly associated with intensive hospital treatment, followed by long term rehabilitation

and other interventions to assist a child attain maximum functioning. However, in spite of the obvious need for services among this population, health insurance and extended medical coverage for children is often lacking or limited to institutional services. There are not cost-effective for insurers, and are disruptive to children and their families.

For many children with disabilities or chronic medical conditions, preventive services are necessary to avert these from becoming more complex medical problems. Timely and appropriate services to maximize or restore functioning, or prevent or limit further deterioration can help children to reach their fullest potential. According to 1992 National Health Insurance Survey data, there are approximately 12.1 million children with some form of chronic medical condition. Of these children, 3.76 million under 18 years of age have some form of physical or mental disability. Many of the chronic illnesses and disabilities that children and adolescents experience are not preventable, such as cystic fibrosis, congenital heart disease, Down's syndrome, and sickle-cell disease. Others, such as cancer, arthritis, diabetes, renal failure develop during childhood yet effective preventive measures are unknown. Until effective means of primary prevention are developed, the emphasis for many chronic illnesses must be on secondary and tertiary prevention; namely, early identification, intervention, and treatment. In order to prevent more significant disability-related conditions and costs from developing, prevention is an essential component in the care of children with special health needs.

Previous experience at the State and local level has demonstrated that long term care services available in the home to the child and their family provide a favorable alternative to impersonal, expensive hospital care. Long term care home and community-based services include benefits such as personal assistance services, habilitation and rehabilitation, transportation, respite services, and others that assist the child in improving or maintaining their health status while remaining at home with their families. Home and community-based services have been shown to be a cost-effective alternative to expensive hospital care, while keeping the entire family intact and facilitating the social and emotional development of the child.

Health insurance for this young population often does not cover essential long term care services such as personal assistance services, respite care, transportation, and home modifications. Few basic private or public policies cover the scope of long term care services, and supplemental coverage is generally expensive and very limited in duration. Many children with disabilities are unable to qualify for private health insurance coverage due to preexisting conditions exclusions or are ineligible for Medicaid due to family income or asset levels. Overall, 15 percent of children with disabilities were completely uninsured. Of children living in poverty, 2 out of 5 children with disabilities are not enrolled in Medicaid.

Little is known about the total costs to the family for medical services for chronically ill children. Too often families have had to spend down into poverty in order to obtain essential services for their children due to strict income and asset levels for Medicaid. Families with private health insurance coverage often face limits in

the scope of duration of necessary services covered by the health plan. Consequently, these families have to choose between enormous out-of-pocket costs or forgoing medical services due to income limitations, even when services are cost-effective in reducing further disabilities and medical costs. The only other option available to families with excessive medical costs is institutional the child rather than attempting to provide care at home.

To date, State and Federal long term care programs have been limited to predominantly institutional care. In 1992, 85 percent of all Federal-State Medicaid long term care expenditures were spent on institutional care. Some States have used home and community-based waivers and Section 1902(e)(3) of the Social Security Act to waive the deeming of parental income and assets for children with disabilities in order to maintain the child at home if shown as a cost-effective alternative to hospitalization. The Federal Title V Maternal and Child Health programs have served as an important source for care coordination and services for children with special needs, but in many States services are lacking and remain disjointed with many children falling through the cracks. Finally, due to State budget constraints or limited interest in developing alternative programs for the medical coverage of the children or adults with disabilities, slow progress has been made on a local level in meeting the needs.

Several States have initiated innovative programs to meet the health insurance needs of this population. For example, Massachusetts created the CommonHealth program in 1988 to serve working adults and children with disabilities. The children's component of CommonHealth enables families to purchase health insurance through the State Medicaid system for their child on a sliding-scale; these families are not eligible for Medicaid coverage due to income or asset limits. In 1993, over 1,500 families were enrolled in the program. The committee has heard testimony to the fact that the program enjoys strong support and satisfaction from most providers, families, and advocates. The health care coverage options for families eliminate social and health system disincentives; specifically, family impoverishment as a means of attaining health insurance and those facing job-lock situations. Other state reforms have targeted insurance practices which place disabled populations at risk of being uninsured.

In the vast majority of States, insurance reforms have not addressed the needs of most families of children with disabilities and chronic health conditions. Premium costs remain too high for most families to afford insurance coverage and insurance reform of small group practices does not correct for the discriminatory practices of employers concerned with the high cost of health insurance premiums. Families continue to carry the greatest burden of care for children with disabilities—often leading to impoverishment of the family or institutionalization of the child.

SUMMARY

The American health care system is badly in need of comprehensive reform. The key problems are: the large and growing number of the uninsured; the lack of health security even for families that currently have insurance; excessive health care cost inflation and

a health system riddled with inefficiency and waste; inadequate access to care for millions of people; and lack of affordable long-term care for senior citizens and younger people with disabilities.

IV. TABULATION OF VOTES

The committee acted upon the following amendments to titles I, II, III, V, VI, VIII, IX, X, and XI of the Chairman's mark. There were a total of 82 amendments offered. Forty-four amendments were adopted or accepted by the committee; they are reflected in the Chairman's mark as reported out of the committee.

RESULTS

May 19, 1994

The Chairman's amendments to title I were incorporated in the Chairman's mark.

Kassebaum amendment No. 1, to make various modifications in the benefits provisions, was tabled, and then withdrawn.

Senator Coats amendment No. 1, regarding the Congressional Budget Office, failed by a roll call vote of 10 nays/7 yeas. Votes against: Senators Kennedy, Pell, Metzenbaum, Dodd, Simon, Harkin, Mikulski, Bingaman, Wellstone, Wofford. Votes for: Senators Kassebaum, Jeffords, Coats, Gregg, Thurmond, Hatch, Durenberger.

Senator Gregg amendment No. 1, regarding health care provider choice (section 1003), was modified and accepted.

Senator Gregg amendment No. 2, regarding adding a new subsection (5) to section 1003, to maintain existing health insurance, failed by a roll call vote of 13 nays/4 yeas. Votes against: Senators Kennedy, Pell, Metzenbaum, Dodd, Simon, Harkin, Mikulski, Bingaman, Wellstone, Wofford. Votes for: Senators Coats, Gregg, Thurmond, Hatch.

Senator Gregg amendment No. 3, regarding individual consumer choice (section 1507), was modified and accepted.

Senator Bingaman amendment No. 1, regarding benefits, and offered as an alternative to Kassebaum amendment No. 1, was modified, and passed by a roll call vote of 17 yeas/0 nays. Unanimous vote.

May 24, 1994

Senator Gregg amendment No. 4, to section 2102(a)(1)(D), regarding eligibility (means testing for individuals above 300 percent of poverty), failed by a roll call vote of 15 nays/2 yeas. Votes against: Senators Kennedy, Pell, Metzenbaum, Dodd, Simon, Harkin, Mikulski, Bingaman, Wellstone, Wofford, Kassebaum, Jeffords, Thurmond, Hatch, Durenberger. Votes for: Senators Coats, Gregg.

Senator Coats amendment No. 2, to title II, part I (subparts A and B), regarding cash payments, failed by a roll call vote of 15 nays/2 yeas. Votes against: Senators Kennedy, Metzenbaum, Dodd, Simon, Harkin, Mikulski, Bingaman, Wellstone, Wofford, Kassebaum, Jeffords, Thurmond, Hatch, Durenberger. Votes for: Senators Coats, Gregg.

Senator Gregg Amendment No. 5, to title II, regarding long-term care coverage was divided. No. 5a, to strike part III, failed by a roll

call vote of 11 nays/6 yeas, and No. 5b, to add language to part III, section 2301, was accepted by a voice vote. Votes against: Senators Kennedy, Pell, Metzenbaum, Dodd, Simon, Harkin, Mikulski, Bingaman, Wellstone, Wofford, Jeffords. Votes for: Senators Kassebaum, Coats, Gregg, Thurmond, Hatch, Durenberger.

The Chairman's amendments to titles III (numbering four) were incorporated in the Chairman's mark.

Senators Kassebaum amendment No. 2, to title III, subtitle K, sections 3082 and 3083, to eliminate certain public health initiatives, failed by a roll call vote of 10 nays/7 yeas. Votes against: Senators Kennedy, Pell, Metzenbaum, Dodd, Simon, Harkin, Mikulski, Bingaman, Wellstone, Wofford. Votes for: Senators Kassebaum, Jeffords, Coats, Gregg, Thurmond, Hatch, Durenberger.

Senator Coats amendment No. 3, modifying sense of the committee amendment to section 3201(a), was accepted by a voice vote.

Senator Dodd amendment No. 1, to include injury prevention in the research and grant programs, was accepted by unanimous consent.

May 25, 1994

Senator Kassebaum amendment No. 3, to facilitate changes in the medical education system, failed by a roll call vote of 11 nays/6 yeas. Votes against: Senators Kennedy, Pell, Metzenbaum, Dodd, Simon, Harkin, Mikulski, Bingaman, Wellstone, Wofford, Gregg. Votes for: Senators Kassebaum, Jeffords, Coats, Thurmond, Hatch, Durenberger.

Senator Kassebaum amendment No. 4, regarding public health block grant, was temporarily set aside. (See May 26—compromise adopted)

Senator Kassebaum amendment No. 5, regarding school health education, was temporarily set aside. (See May 26—compromise adopted)

Senators Durenberger/Kennedy amendment No. 1, to modify provisions relating to mental health and substance abuse, was set aside.

Senator Kassebaum amendment No. 6, regarding healthy students/healthy schools interagency task force, was withdrawn, with the exception of lines 3–10, which were accepted by unanimous consent.

Senator Hatch amendment No. 1, regarding community and migrant health centers, was accepted by unanimous consent.

May 26, 1994

The Chairman's amendments to titles II and V were incorporated in the Chairman's mark.

Senator Gregg amendment No. 6 to title V, regarding striking section 5232, administrative and judicial review relating to cost containment, was withheld.

Senator Hatch amendment No. 2, to strike enterprise liability demonstration language, and replace it, was set aside.

Senator Hatch amendment No. 3, modified, to cap punitive damages, failed by a roll call vote of 10–7. Votes against: Senators Kennedy, Pell, Metzenbaum, Dodd, Simon, Harkin, Mikulski, Binga-

man, Wellstone, Wofford. Votes for: Senators Kassebaum, Jeffords, Coats, Gregg, Thurmond, Hatch, Durenberger.

Senator Hatch amendment No. 4, to require States to establish scale of caps for non-economic damages, failed by a roll call vote of 12-5. Votes against: Senators Kennedy, Pell, Metzenbaum, Dodd, Simon, Harkin, Mikulski, Bingaman, Wellstone, Wofford, Jeffords, Gregg. Votes for: Senators Kassebaum, Coats, Thurmond, Hatch, Durenberger.

Senator Hatch amendment No. 5, requiring a 25 percent across-the-board cap on attorney's fees, passed by a roll call vote of 11-6. Votes for: Senators Pell, Dodd, Simon, Mikulski, Kassebaum, Jeffords, Coats, Gregg, Thurmond, Hatch, Durenberger. Votes against: Senators Kennedy, Metzenbaum, Harkin, Bingaman, Wellstone, Wofford.

Senator Metzenbaum amendment No. 1, regarding attorney's fees, passed by a roll call vote of 9-8. Votes for: Senators Metzenbaum, Simon, Harkin, Mikulski, Bingaman, Wellstone, Wofford, Jeffords. Votes against: Senators Kennedy, Pell, Dodd, Kassebaum, Coats, Gregg, Thurmond, Hatch, Durenberger.

Senator Kassebaum amendment No. 7, to titles I and V, to modify provisions relating to anti-discrimination, was tabled.

Senators Kennedy/Kassebaum amendment No. 1, to title III, to modify provisions relating to school-related health services, passed by a roll call vote of 17-0. Unanimous vote.

Senator Thurmond amendment No. 1, to strike subtitle E of title V, regarding the McCarran-Ferguson Act, failed by a roll call vote of 10 nays/7 yeas. Votes against: Senators Kennedy, Pell, Metzenbaum, Dodd, Simon, Mikulski, Bingaman, Wellstone, Wofford, Durenberger. Votes for: Senators Harkin, Kassebaum, Jeffords, Coats, Gregg, Thurmond, Hatch.

Senators Jeffords/Dodd amendment No. 1, to create a Federal uniform claims resolution procedure, failed by a roll call vote of 9 nays/8 yeas. Votes against: Senators Kennedy, Pell, Metzenbaum, Simon, Harkin, Mikulski, Bingaman, Wellstone, Wofford. Votes for: Senators Dodd, Kassebaum, Jeffords, Coats, Gregg, Thurmond, Hatch, Durenberger.

Senators Kennedy/Kassebaum amendment No. 2, to modify provisions relating to core functions of public health, passed by a roll call vote of 17-0. Unanimous vote.

Senator Harkin amendment No. 1, to expand the opportunities for careers in rural health, residency programs in rural health, and telemedicine, was accepted without objection.

Senator Gregg amendment No. 7, to strike section 5241(b), facial constitutional challenges, accepted without objection.

Senator Coats amendment No. 4, to title V, sections 5302(d) and 5304(a) regarding State malpractice laws, was accepted without objection.

June 7, 1994

Senator Wellstone amendment No. 1, to provide due process for health care providers, passed by a roll call vote of 13 yeas/4 nays. Votes for: Senators Kennedy, Pell, Metzenbaum, Dodd, Simon, Harkin, Mikulski, Bingaman, Wellstone, Wofford, Kassebaum, Jeffords,

Hatch. Votes against: Senators Coats, Gregg, Thurmond, Durenberger.

Oops—my error. Durenberger voted against, Hatch for.

Senator Coats amendment No. 5, to section 5104, to require written consent prior to the disclosure of certain information, accepted.

Senator Coats amendment No. 6, to exclude abortions from the comprehensive benefit package except in certain circumstances, failed by a roll call vote of 11 nays/6 yeas. Votes against: Senators Kennedy, Pell, Metzenbaum, Dodd, Simon, Harkin, Mikulski, Bingaman, Wellstone, Wofford. Votes for: Senators Kassebaum, Coats, Gregg, Thurmond, Hatch, Durenberger.

Senator Gregg amendment No. 8, regarding State laws' regulation of abortion, failed by a roll call vote of 10 nays/7 yeas. Votes against: Senators Kennedy, Pell, Metzenbaum, Dodd, Simon, Harkin, Mikulski, Bingaman, Wellstone, Jeffords. Votes for: Senators Wofford, Kassebaum, Coats, Gregg, Thurmond, Hatch, Durenberger.

Senator Kennedy amendment No. 1, offered as a substitute to Gregg amendment, No. 8 withdrawn.

Senator Kassebaum amendment No. 7, on antidiscrimination (originally offered on May 26), withdrawn, and then offered, failing by a roll call vote of 11 nays/6 yeas. Votes against: Senators Kennedy, Pell, Metzenbaum, Dodd, Simon, Harkin, Mikulski, Bingaman, Wellstone, Wofford, Jeffords. Votes for: Senators Kassebaum, Coats, Gregg, Thurmond, Hatch, Durenberger.

Senator Simon amendment No. 1, to ensure health care coverage for U.S. citizens living abroad, was accepted.

Senator Kassenbaum amendment No. 8, revising the benefits provisions, was modified, and failed by a roll call vote of 11 nays/5 yeas. Votes against: Senators Kennedy, Pell, Metzenbaum, Dodd, Simon, Harkin, Mikulski, Bingaman, Wellstone, Wofford, Coats. Votes for: Senators Kassebaum, Jeffords, Thurmond, Hatch, Durenberger.

Senator Harkin amendment No. 2, to expand efforts to combat health care fraud and abuse, was accepted.

Senators Wofford and Kennedy amendment No. 1, to modify provisions in subtitle B of title I, to be revisited. (See June 8)

June 8, 1994

The Chairman's amendments to titles VI and IX were incorporated in the Chairman's mark.

Senator Kassebaum amendment No. 9, to eliminate the employer mandate, failed by a roll call vote of 10 nays/7 yeas. Votes against: Senators Kennedy, Pell, Metzenbaum, Dodd, Simon, Harkin, Mikulski, Wellstone, Wofford, Jeffords. Votes for: Senators Bingaman, Kassebaum, Coats, Gregg, Thurmond, Hatch, Durenberger.

Senator Kassebaum amendment No. 10, to strike provisions relating to new retiree health entitlement, was modified, and failed by a roll call vote of 10 nays/7 yeas. Votes against: Senators Kennedy, Pell, Metzenbaum, Dodd, Simon, Harkin, Mikulski, Bingaman, Wellstone, Wofford. Votes for: Senators Kassebaum, Jeffords, Coats, Gregg, Thurmond, Hatch, Durenberger.

Senator Bingaman amendment No. 2, to section 6116, to provide for a small employer exemption from premium contributions, a

transition for medium-sized employers, a contribution trigger for employers of part-time workers, and a study on employer contributions for seasonal workers, passed by a roll call vote of 11 yeas/6 nays. Votes for: Senators Kennedy, Pell, Metzenbaum, Dodd, Simon, Harkin, Mikulski, Bingaman, Wellstone, Wofford, Jeffords. Votes against: Senators Kassebaum, Coats, Gregg, Thurmond, Hatch, Durenberger.

Senator Durenberger amendment No. 2, to strike the premium caps, failed by a roll call vote of 9 yeas/8 yeas. Votes against: Senators Kennedy, Pell, Metzenbaum, Simon, Harkin, Mikulski, Bingaman, Wellstone, Wofford. Votes for: Senators Dodd, Kassebaum, Jeffords, Coats, Gregg, Thurmond, Hatch, Durenberger.

Senator Jeffords amendment No. 1, to title VI, to adjust premium caps to take into consideration state variations, was set aside.

Senator Coats amendment No. 7, to eliminate the comprehensive benefits package, failed by a roll call vote of 11 nays/6 yeas. Votes against: Senators Kennedy, Pell, Metzenbaum, Dodd, Simon, Harkin, Mikulski, Bingaman, Wellstone, Wofford, Jeffords. Votes for: Senators Kassebaum, Coats, Gregg, Thurmond, Hatch, Durenberger.

Senator Mikulski amendment No. 1, regarding FEHBP offering supplemental plans, accepted by voice vote.

Senator Simon amendment No. 2 to require the Board to consult with the Federal Reserve Board in making recommendations concerning the general health care inflation factor, was accepted.

Senator Simon amendment No. 3, to modify the premium cap structure in title VI was withdrawn.

Senator Pell amendment No. 1, to section 1901(b)(2)(D), regarding full-time employment status for employees of institutions of secondary education, was accepted, subject to further study, per Senator Jeffords' request.

Senator Coats amendment No. 8, to express the sense of the Committee concerning the inclusion of medical savings account provisions in the bill, failed by a roll call vote of 9 yeas/8 yeas. Votes against: Senators Kennedy, Pell, Metzenbaum, Simon, Harkin, Bingaman, Wellstone, Wofford, Durenberger. Votes for: Senators Dodd, Mikulski, Kassebaum, Jeffords, Coats, Gregg, Thurmond, Hatch.

Senator Simon amendment, modifying Senator Coats amendment No. 8, to express the sense of the Committee concerning the inclusion of medical savings account provisions in the bill, passed by a roll call vote of 11 yeas/5 nays. Votes for: Senators Pell, Dodd, Simon, Harkin, Mikulski, Bingaman, Wofford, Kassebaum, Jeffords, Thurmond, Hatch. Votes against: Senators Kennedy, Wellstone, Coats, Gregg, Durenberger.

Senators Wofford and Kennedy amendment No. 1, (originally offered on June 7), was accepted.

Senator Gregg amendment No. 9 (joined by Senator Coats), to strike the National Board, failed by a roll call vote of 11 nays/6 yeas. Votes against: Senators Kennedy, Pell, Metzenbaum, Dodd, Simon, Harkin, Mikulski, Bingaman, Wellstone, Wofford, Jeffords. Votes for: Senators Kassebaum, Coats, Gregg, Thurmond, Hatch, Durenberger.

June 9, 1994

Senator Wellstone amendment No. 2, to add certain provisions relating to utilization management, accepted by voice vote.

Senator Kennedy amendment No. 2 (joined by Senators Mikulski and Dodd), to provide for the conduct of a medical technology impact study, passed by a roll call vote of 16 yeas/1 nay. Votes for: Senators Kennedy, Pell, Dodd, Simon, Harkin, Mikulski, Bingaman, Wellstone, Wofford, Kassebaum, Jeffords, Coats, Gregg, Thurmond, Hatch, Durenberger. Votes against: Senator Metzenbaum.

Senator Metzenbaum amendment No. 2, to require that six members of the board in Senator Kennedy's amendment No. 2, be consumer advocates, failed by a roll call vote of 13 nays/4 yeas. Votes against: Senators Kennedy, Dodd, Harkin, Mikulski, Bingaman, Wofford, Kassebaum, Jeffords, Coats, Gregg, Thurmond, Hatch, Durenberger. Votes for: Senators Pell, Metzenbaum, Simon, Wellstone.

Senator Gregg amendment No. 10, to strike the biotechnology section 1672, failed by a roll call vote of 10 nays/5 yeas. Votes against: Senators Kennedy, Pell, Dodd, Simon, Harkin, Mikulski, Bingaman, Wellstone, Wofford. Votes for: Senators Coats, Gregg, Thurmond, Hatch, Durenberger.

Senator Thurmond amendment No. 2, to remove requirements relating to workers compensation, failed by a roll call vote of 10 nays/7 yeas. Votes against: Senators Kennedy, Pell, Metzenbaum, Dodd, Simon, Harkin, Mikulski, Bingaman, Wellstone, Wofford. Votes for: Senators Kassebaum, Jeffords, Coats, Gregg, Thurmond, Hatch, Durenberger.

Senator Thurmond amendment No. 3, to strike subtitle A of title V, Quality Management and Improvement and permit States to establish standards and performance measures for health plans, failed by a roll call vote of 13 nays/4 yeas. Votes against: Senators Kennedy, Pell, Metzenbaum, Dodd, Simon, Harkin, Mikulski, Bingaman, Wellstone, Wofford, Jeffords, Hatch, Durenberger. Votes for: Senators Kassebaum, Coats, Gregg, Thurmond. Lines (1) through (4) of Thurmond amendment No. 3, to section 5001(b), to limit participation of providers who have been convicted under Federal or State law of criminal offenses, were accepted.

Senator Thurmond amendment No. 4, to extend family enrollment eligibility to dependent children 24 years of age or younger, passed by a roll call vote of 17 yeas/0 nays. Unanimous vote (Chairman stated it will be revisited if CBO determines costs affected by inclusion).

Senator Coats amendment No. 9, to titles 1 and VI, regarding the Amish exemption, was accepted.

Senator Jeffords amendment No. 2, (with Senators Durenberger and Kassebaum), to strike and replace provisions concerning co-operatives and large group sponsors, health plan requirements and large employer requirements, set aside.

Senator Gregg amendment No. 11, to strike section 1012(a), regarding Medicare, failed by a roll call vote of 11 Nays/6 yeas. Votes against: Senators Kennedy, Pell, Metzenbaum, Dodd, Simon, Harkin, Mikulski, Bingaman, Wellstone Wofford, Jeffords. Votes for: Senators Kassebaum, Coats, Gregg, Thurmond, Hatch, Durenberger.

Senator Hatch amendment No. 7 (with Senator Kennedy), to modify medical malpractice reform provisions (early neutral evaluation and state demonstration projects), accepted by a voice vote.

Senator Simon amendment No. 4, to require, the Federal Reserve Board to conduct a study concerning the general health care inflation factor, accepted.

Senator Wofford amendment No. 1 (with Senator Dodd), to establish a national health care data network and to establish requirements with respect to the privacy of personally identifiable health care information, accepted by a voice vote.

Senator Hatch amendment No. 8, to add colorectal screening to the comprehensive benefit package, passed by voice vote.

Senator Kennedy amendment No. 3 (with Senator Wellstone) to modify provisions relating to the mental health and substance abuse benefit, passed by a roll call vote of 14 yeas/3 nays. Votes for: Senators Kennedy, Pell, Metzenbaum, Dodd, Simon, Harkin, Mikulski, Bingaman, Wellstone, Wofford, Kassebaum, Jeffords, Thurmond, Hatch. Votes against: Senators Coats, Gregg.

Senator Kennedy amendment No. 4, to make technical and miscellaneous changes in title X (workers compensation), was modified and accepted by voice vote. Senator Bingaman change to page 9 of the amendment, accepted).

Senator Hatch amendment No. 9, with Senator Coats), to eliminate the threshold of 1,000 full-time employees to all employers the option to self-insure employees for health care benefits, failed by a roll call vote of 13 nays/4 yeas. Votes against: Senators Kennedy, Pell, Metzenbaum, Dodd, Simon, Harkin, Mikulski, Bingaman, Wellstone, Wofford, Kassebaum, Jeffords, Durenberger. Votes for: Senators Coats, Gregg, Thurmond, Hatch.

Senator Kennedy amendment No. 5, to sections 3081 and 3082, to establish an advisory board on health care workforce development, and for other purposes, was accepted.

Senator Dodd amendment No. 2, to section 1603, regarding benefits (the original Bingaman amendment No. 1, prior to modification), was accepted by a roll call vote of 10 yeas/7 nays. Votes for: Senators Dodd, Mikulski, Bingaman, Kassebaum, Jeffords, Coats, Gregg, Thurmond Hatch, Durenberger. Votes against: Senators Kennedy, Pell, Metzenbaum, Simon, Harkin, Wellstone, Wofford.

Senator Harkin amendment No. 3, to amending Bingaman amendment No. 1 (modified version), failed by a roll call vote of 10 nays/6 yeas. Votes against: Senators Dodd, Mikulski, Wellstone, Kassebaum, Jeffords, Coats, Gregg, Thurmond, Hatch, Durenberger. Votes for: Senators Kennedy, Metzenbaum, Simon, Harkin, Bingaman, Wofford.

Senator Jeffords amendment No. 2, (revisited), failed by a roll call vote of 12 nays/5 yeas. Votes against: Senators Kennedy, Pell, Metzenbaum, Dodd Simon, Harkin, Mikulski, Bingaman, Wellstone, Wofford, Coats, Gregg. Votes for: Senators Kassebaum, Jeffords, Thurmond, Hatch, Durenberger.

Senator amendment No. 3, modifying Jeffords amendment No. 2 regarding administrative structure, passed by a roll call vote of 9 yeas/8 nays. Votes for: Senators Kennedy, Pell, Dodd, Simon, Harkin, Mikulski, Bingaman, Wofford, Jeffords. Votes against: Sen-

ators Metzenbaum, Wellstone, Kassebaum, Coats, Gregg, Thurmond, Hatch, Durenberger.

Chairman's technical and miscellaneous amendments accepted.

S. (original bill), The Health Security Act, was reported out of Committee by a roll call vote of 11 yeas/6 nays. Votes for: Senators Kennedy, Pell, Metzenbaum, Dodd, Simon, Harkin, Mikulski, Bingaman, Wellstone, Wofford, Jeffords. Votes against: Senators Kassebaum, Coats, Gregg, Thurmond, Hatch, Durenberger.

V. COST ESTIMATE

Pursuant to rule 26, paragraph 11(a), the committee estimates that the legislation will be approximately budget neutral in the 5 fiscal years 1995–1999 and will reduce the deficit in subsequent years. This estimate is based on the Congressional Budget Office (CBO) estimate of the Health Security Act as submitted by the Clinton administration. Modifications to the Health Security Act as submitted included in the reported bill were estimated by the committee staff based on technical input and advice and preliminary estimates by the Office of Management and Budget, the Congressional Research Service, and the Congressional Budget Office.

No estimate by the Congressional Budget Office has been included in this report because the CBO has been unable to produce such an estimate by the committee's target filing date. The committee anticipates that such an estimate will be available prior to any floor consideration of the bill as reported. The committee concluded that providing a timely opportunity for the members of the Senate and the availability of an official CBO estimate appropriate.

VI. REGULATORY IMPACT STATEMENT

In accordance with paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the following statement of the regulatory impact of the Health Security Act is made:

A. ESTIMATED NUMBER OF INDIVIDUALS AND BUSINESSES WHO WOULD BE REGULATED AND THEIR GROUPS AND CLASSIFICATIONS

It is estimated that, at full implementation, the Health Security Act would affect approximately 5.7 million private businesses and .8 million farms employing approximately 112 million people. The bill would ultimately affect the entire nonelderly population—roughly 220 million people.

B. ECONOMIC IMPACT ON THE INDIVIDUALS, CONSUMERS, AND BUSINESSES AFFECTED

Except for small businesses exempted under the bill, all employers are required to contribute toward the coverage of their workers and their workers' families. This requirement will result in additional costs for those businesses not currently insuring their workers.

The cost to business will be 80 percent of the average priced premium for employee-only coverage. Preliminary estimates indicate that for family coverage (either a married couple or two parents and children), a company would pay approximately 55 percent of the premium—reflecting the averaging of the cost for families with

more than one working adult across several employers. Employer payments on behalf of each employee will be capped at 12 percent of the wages of the employee.

To ensure affordability for medium size firms (those with fewer than 75 employees and average wages of no more than \$24,000 a year), this maximum percentage is reduced on a sliding scale to as low as 4.2 percent of each employee's wages. Thus, for a company with 12 employees and average annual wages of \$12,000, the cost of the requirement will be 24 cents per employee per hour.

Additionally, the bill exempts small businesses from the required contribution if they have 10 or fewer employees and average wages of no more than \$24,000 a year. Approximately 60 percent of all firms in the country would qualify for this exemption. In lieu of premium contributions, these firms would pay an assessment: 1 percent of payroll for firms with five or fewer employees, and 2 percent of payroll for firms with six to ten employees.

Businesses currently providing comprehensive health benefits will experience savings as a result of the elimination of cost-shifting from firms that don't provide coverage and from the millions of uninsured or underinsured Americans. Additionally, many of these firms will qualify for the exemption and subsidies mentioned above. It is anticipated that savings will grow with time due to the cost-containment provisions of the bill.

Families working in firms other than exempt small business will have their premiums capped at a maximum of 3.9 percent of income—less for families with incomes below 150 percent of the Federal poverty level.

Families working for exempt small businesses would pay somewhat more to compensate for the lack of employer payment—but no more than 4 to 6 percent of their income. The self-employed are also eligible for discounts and have full tax-deductibility of their premium payments.

Nonworkers have their payments for coverage capped on a sliding scale up to 9.6 percent of unearned income. These families are not liable for any payment on unemployment compensation and a monthly earned income set-aside of up to \$5,000.

Because the bill provides for a comprehensive benefits package, consumers will be protected against catastrophic medical bills.

The currently uninsured and underinsured with few medical expenses could see an increase in costs due to the requirement to purchase comprehensive coverage.

C. IMPACT OF THE ACT ON PERSONAL PRIVACY

The legislation will enhance personal privacy. First, the bill provides a set of rules—where there are none today—to limit and protect the disclosure and use of individually identifiable medical information. Furthermore, the bill's insurance reforms mean that individuals will no longer have to disclose medical information to an employer or insurer as a condition of receiving employment-based coverage.

D. ADDITIONAL PAPERWORK, TIME, AND COSTS

The legislation reduces paperwork for families. Possession of a health security card means that patients will no longer have to fill

out numerous forms to receive medical treatment. The elimination of medical underwriting and exclusion of preexisting conditions from coverage means that individuals will not have to submit to pre-coverage questionnaires regarding health status.

All families would be required to fill out an enrollment form and, to receive discounts, a subsidy application form.

Employers currently providing coverage could see a decrease in paperwork requirements, largely due to the insurance reforms and the option to join a consumer purchasing cooperative. Some information will be required from employers to verify payments and to reconcile discounts. Likewise, firms not providing coverage today would be required to provide for payroll deductions of their employee's premium payments.

VII. SECTION-BY-SECTION ANALYSIS

Title I

SUBTITLE A. UNIVERSAL COVERAGE AND INDIVIDUAL RESPONSIBILITY

Part 1. Universal coverage

Sec. 1001. Entitlement to health benefits

In accordance with this part, each eligible individual is entitled to the comprehensive benefit package under subtitle B through the applicable health plan in which the individual is enrolled consistent with this title. Each eligible individual is entitled to a health security card to be issued by the applicable health plan in which the individual is enrolled.

In this act, the term "eligible individual" means an individual who is residing in the United States and who is—

(1)(A) a citizen or national of the United States;

(B) an alien permanently residing in the United States under color of law (as defined in Section 1902(1)); or

(C) a long-term nonimmigrant (as defined in Section 1902(19)), and

(2) not an exempt individual (as defined in Section 1902(18)).

(d) TREATMENT OF MEDICARE-ELIGIBLE INDIVIDUALS.—Subject to section 1012(a), a Medicare-eligible individual is entitled to health benefits under the medicare program instead of the entitlement under subsection (a).

(e) TREATMENT OF PRISONERS.—A prisoner (as defined in section 1902(37)) is entitled to health care services provided by the authority responsible for the prisoner instead of the entitlement under subsection (a).

Sec. 1002. Individual Responsibilities

(a) IN GENERAL.—In accordance with this act, each eligible individual (other than a medicare-eligible individual) must enroll in an applicable health plan for the individual, and pay any premium required, consistent with this act, with respect to such enrollment.

(b) LIMITATION ON DISENROLLMENT.—No eligible individual shall be disenrolled from an applicable health plan until the individual

(1) is enrolled under another applicable health plan, or

(2) becomes a medicare-eligible individual.

Sec. 1003. Protection of consumer choice

Nothing in this act shall be construed as prohibiting the following:

- (1) an individual from purchasing any health care services.
- (2) An individual from purchasing supplemental insurance (offered consistent with this act) to cover health care services not included within the comprehensive benefit package.
- (3) An individual who is not an eligible individual from purchasing health insurance) other than through a regional alliance).
- (4) Employers from providing coverage for benefits in addition to the comprehensive benefit package (subject to part 2 of subtitle E).
- (5) an individual from obtaining (at the expense of such individual) health care from any health care provider of such individual's choice.

Sec. 1004. Health plan principles

In accordance with this act, the following principles shall apply to all health plans:

- (1) No health plan may discriminate on the basis of medical history, pre-existing medical conditions, or genetic predisposition to medical conditions.
- (2) A health plan—
 - (A) Shall offer an annual open enrollment period and accept all eligible individuals for coverage;
 - (B) Shall not impose a rider that serves to exclude coverage to an individual; and
 - (C) Shall not impose waiting periods before coverage begins.
- (3) A health plan shall ensure that all medically necessary or appropriate services, as defined in the benefits package, are provided, including access to specialty care.
- (4) Health benefits coverage shall be portable from one health plan to another.

Nothing in this section shall be construed so as to relieve a health plan of any obligation or requirement imposed under this act.

Sec. 1005. Applicable health plan providing coverage

(a) SPECIFICATION OF APPLICABLE HEALTH PLAN.—Except as otherwise provided:

(1) GENERAL RULE: COMMUNITY RATED HEALTH PLANS.—The applicable health plan for a family is a community rated health plan for the health care coverage area in which the family resides.

(2) EXPERIENCE RATED HEALTH PLANS.—In the case of a family member that is eligible to enroll in an experience rated health plan, the applicable health plan for the family is such an experience rated health plan.

(b) CHOICE OF PLANS FOR CERTAIN GROUPS.—(1) For military personnel and families who elect a Uniformed Services Health Plan of the Department of Defense under section 1073a(d) of title 10,

United States Code, as inserted by Section 8001(a) of this Act, that plan shall be the applicable health plan.

(2) For veterans and families who elect to enroll in a veterans health plan under section 1801 of title 38, United States Code, as inserted by section 8101(a) of this Act, that plan shall be the applicable health plan.

(3) For those individuals who are eligible to enroll, and who elect to enroll, in a health program of the Indian Health Service under section 8302(b) or 8306(b), that program shall be the applicable health plan.

Sec. 1006. Treatment of other nonimmigrants

(a) CERTAIN ALIENS INELIGIBLE FOR BENEFITS.—An alien who is not an eligible individual or otherwise made eligible under this act for benefits is not eligible to obtain the comprehensive benefit package through enrollment in a health plan pursuant to this Act.

(b) DIPLOMATS AND OTHER FOREIGN GOVERNMENT OFFICIALS.—Subject to conditions established by the National Health Board in consultation with the Secretary of State, a nonimmigrant under subparagraph (A) or (G) of Section 101(a)(15) of the Immigration and Nationality Act may obtain the comprehensive benefit package through enrollment in a community rated health plan for the health care coverage area in which the nonimmigrant resides.

(c) RECIPROCAL TREATMENT OF OTHER NONIMMIGRANTS.—With respect to those classes of individuals who are lawful nonimmigrants but who are not long-term nonimmigrants (as defined in Section 1902) or described in subsection (b), such individuals may obtain such benefits through enrollment with a community rated health plan only in accordance with such reciprocal agreements between the United States and foreign states as may be entered into.

(d) The National Health Board shall adopt procedures that assure that each person who is eligible for enrollment in an applicable health plan is able to enroll in such a plan.

Sec. 1007. Effective date of entitlement

(a) COMMUNITY RATE ELIGIBLE INDIVIDUALS.—(1) IN GENERAL.—In the case of community rate eligible individuals residing in a State, the entitlement under this part (and requirements under Section 1002) shall not take effect until the State becomes a participating State (as defined in Section 1200).

(2) TRANSITIONAL RULE FOR LARGE GROUP SPONSORS.—

(A) IN GENERAL.—In the case of a State that becomes a participating State before the general effective date (as defined in subsection (c)) and for periods before such date, under rules established by the Board, an individual who is covered under a plan (described in subparagraph (C)) based on the individual (or the individual's spouse) being a qualifying employee of a qualifying employer, the individual shall not be treated under this act as a community rate eligible individual.

(B) QUALIFYING EMPLOYER DEFINED.—In subparagraph (A), the term "qualifying employer" means an employer that—

(i) Is described in Section 1401(2), or is participating in a multiemployer plan described in Section 1401(6)(B) or plan described in Section 1401(7), and

(ii) Provides such notice to the State involved as the Board specifies.

(C) **BENEFITS PLAN DESCRIBED.**—A plan described in this subparagraph is an employee benefit plan that—

(i) Provides (through insurance or otherwise) the comprehensive benefit package, and

(ii) Provides an employer contribution of at least 80 percent of the premium (or premium equivalent) for coverage.

(b) **ELIGIBLE INDIVIDUALS.**—(1) **IN GENERAL.**—In the case of experience rate eligible individuals, the entitlement under this part shall not take effect until the general effective date.

(2) **TRANSITION.**—For purposes of this act and before the general effective date, in the case of an eligible individual who resides in a participating State, the individual is deemed a community rate eligible individual until the individual becomes an experience rate eligible individual, unless subsection (a)(2)(A) applies to the individual.

(c) **GENERAL EFFECTIVE DATE DEFINED.**—In this act, the term “general effective date” means January 1, 1998.

Part 2. Treatment of families and special rules

Sec. 1011. General rule of enrollment of family in same health plan

(a) **IN GENERAL.**—Except as provided in this part or otherwise, all members of the same family (as defined in subsection (b)) shall be enrolled in the same applicable health plan.

(b) **FAMILY DEFINED.**—In this act, unless otherwise provided, the term “family”

(1) Means, with respect to an eligible individual who is not a child (as defined in subsection (c)), the individual; and

(2) Includes the following persons (if any):

(A) The individual’s spouse if the spouse is an eligible individual.

(B) The individual’s children (and, if applicable, the children of the individual’s spouse) if they are eligible individuals.

(c) **CLASSES OF FAMILY ENROLLMENT; TERMINOLOGY.**—

(1) **IN GENERAL.**—In this act, each of the following is a separate class of family enrollment:

(A) Coverage only of an individual (referred to in this act as the “individual” enrollment or class of enrollment).

(B) Coverage of a married couple without children (referred to in this act as the “couple-only” enrollment or class of enrollment).

(C) Coverage of an unmarried individual and one or more children (referred to in this act as the “single parent” enrollment or class of enrollment).

(D) Coverage of a married couple and one or more children (referred to in this act as the “dual parent” enrollment or class of enrollment).

(2) REFERENCES TO FAMILY AND COUPLE CLASSES OF ENROLLMENT.—In this act:

(A) FAMILY.—The terms “family enrollment” and “family class of enrollment”, refer to enrollment in a class of enrollment described in subparagraph (B), (C), or (D) of paragraph (1).

(B) COUPLE.—The term “couple class of enrollment” refers to enrollment in a class of enrollment described in subparagraph (B) or (D) of paragraph (1).

(d) SPOUSE; MARRIED; COUPLE.—

(1) IN GENERAL.—In this act, the terms “spouse” and “married” means, with respect to a person, another individual who is the spouse of the person or married to the person, as determined under applicable State law.

(2) COUPLE.—The term “couple” means an individual and the individual’s spouse.

(e) CHILD DEFINED.—

(1) IN GENERAL.—In this act, except as otherwise provided, the term “child” means an eligible individual who (consistent with paragraph (3)).

(A) Is under 25 years of age, and

(B) Is a dependent of an eligible individual.

(2) APPLICATION OF STATE LAW.—Subject to paragraph (3), determinations of whether a person is the child of another person shall be made in accordance with applicable State law.

(3) NATIONAL RULES.—The National Health Board may establish such national rules respecting individuals who will be treated as children under this act as the Board determines to be necessary. Such rules shall be consistent with the following principles:

(A) STEP CHILD.—A child includes a step child who is an eligible individual living with an adult in a regular parent-child relationship.

(B) DISABLED CHILD.—A child includes an unmarried dependent eligible individual regardless of age who is incapable of self-support because of mental or physical disability which existed before age 21.

(C) CERTAIN 3-GENERATION FAMILIES.—A child includes the grandchild of an individual, if the parent of the grandchild is a child and the parent and grandchild are living with the grandparent, or if the grandparent has legal custody of the child.

(D) TREATMENT OF EMANCIPATED MINORS AND MARRIED INDIVIDUALS.—An emancipated minor or married individual shall not be treated as a child.

(E) CHILDREN PLACED FOR ADOPTION.—A child includes a child who is placed for adoption with an eligible individual.

(f) SPOUSES LIVING IN DIFFERENT HEALTH CARE COVERAGE AREAS.—The board shall provide for special rules in the case of a couple in which spouses reside in different health care coverage areas.

(g) STATE-SUPERVISED CARE.—In the case of a qualifying child in State-supervised care, the child be considered a family of one and enrolled by the State agency who has been awarded temporary of

permanent custody of the child in a fee-for-service plan unless the State agency has established a special delivery system designed especially for such children.

Sec. 1012. TREATMENT OF CERTAIN FAMILIES

(a) TREATMENT OF MEDICARE-ELIGIBLE INDIVIDUALS WHO ARE QUALIFYING EMPLOYEES OR SPOUSES OF QUALIFYING EMPLOYEES.—

(1) **IN GENERAL.**—Except as specifically provided, in the case of an individual who is an individual described in paragraph (2) with respect to 2 consecutive months in a year (and it is anticipated would be in the following month and in such following month would be a medicare-eligible individual but for this paragraph), the individual shall not be treated as a medicare-eligible individual under this act during such following month and the remainder of the year.

(2) **INDIVIDUAL DESCRIBED.**—An individual described in this paragraph with respect to a month is an individual who is a qualifying employee or the spouse or family member of a qualifying employee in the month.

(b) SEPARATE TREATMENT FOR CERTAIN GROUPS OF INDIVIDUALS.—In the case of a family that includes one or more individuals in a group described in subsection (c).

(1) All the individuals in each such group within the family shall be treated collectively as a separate family, and

(2) All the individuals not described in any such group shall be treated collectively as a separate family.

(c) GROUPS OF INDIVIDUALS DESCRIBED.—Each of the following is a group of individuals described in this subsection:

(1) AFDC recipients (as defined in Section 1902).

(2) Disabled SSI recipients (as defined in Section 1902).

(3) SSI recipients (as defined in Section 1902) who are not disabled SSI recipients.

(4) Electing veterans (as defined in subsection (d)(1)).

(5) Active duty military personnel (as defined in subsection (d)(2)).

(6) Electing Indians (as defined in subsection (d)(3)).

(7) Prisoners (as defined in Section 1902).

(d) SPECIAL RULES.—In this act:

(1) ELECTING VETERANS.—

(A) **DEFINED.**—Subject to subparagraph (B), the term “electing veteran” means a veteran who makes an election to enroll with a health plan of the Department of Veterans Affairs under chapter 18 of title 38, United States Code, as added by Section 8101(a)(1).

(B) **FAMILY EXCEPTION.**—Subparagraph (A) shall not apply with respect to coverage under a health plan referred to in such subparagraph if, for the area in which the electing veteran resides, such health plan offers coverage to family members of an electing veteran and the veteran elects family enrollment under such plan (instead of individual enrollment).

(2) ACTIVE DUTY MILITARY PERSONNEL.—

(A) IN GENERAL.—Subject to subparagraph (B), the term “active duty military personnel” means an individual on active duty in the Uniformed Services of the United States.

(B) EXCEPTION.—If an individual described in subparagraph (A) elects family coverage under Section 1073a(e)(2)(A) of title 10, United States Code (as added by Section 8001(a)), then paragraph (5) of subsection (c) shall not apply with respect to such coverage.

(3) ELECTING INDIANS.—

(A) IN GENERAL.—Subject to subparagraph (B), the term “electing Indian” means an eligible individual who makes an election under Section 8302(b) of this act.

(B) FAMILY ELECTION FOR ALL INDIVIDUALS ELIGIBLE TO ELECT.—No such election shall be made with respect to an individual in a family (as defined without regard to this Section) unless such election is made for all eligible individuals (described in Section 8302(a)) who are family members of the family.

(4) MULTIPLE CHOICE.—Eligible individuals who are permitted to elect coverage under more than one health plan or program referred to in this subsection may elect which of such plans or programs will be the applicable health plan under this act.

(e) QUALIFYING STUDENTS.—

(1) IN GENERAL.—In the case of a qualifying student (described in paragraph (2)), the student may elect to enroll in a community rate health plan offered for the health care coverage area in which the school is located.

(2) QUALIFYING STUDENT.—In paragraph (1), the term “qualifying student” means an individual who

(A) But for this subsection would receive coverage under a health plan as a child of another person, and

(B) Is a full-time student at a school in a health care coverage area that is different from the area (or, in the case of a large group sponsor, such coverage area as the Board may specify) providing the coverage described in subparagraph (A).

(3) PAYMENT RULES.—

(A) CONTINUED TREATMENT AS FAMILY.—Except as provided in subparagraph (B), nothing in this subsection shall be construed as affecting the payment liabilities between families and community rated health plans.

(B) TRANSFER PAYMENT.—In the case of an election under paragraph (1), for transfer payments see Section 1238.

(f) SPOUSES LIVING IN DIFFERENT HEALTH CARE COVERAGE AREAS.—The Board shall provide for such special rules in applying this act in the case of a couple in which the spouses reside in different health care coverage areas as the Board finds appropriate.

(g) CHILDREN IN STATE SUPERVISED CARE.—

(1) IN GENERAL.—In the case of a qualifying child in State supervised care (as described in paragraph (2)), the child shall be considered as a family of one and enrolled by the State agency who has been awarded temporary or permanent cus-

tody of the child (or which has legal responsibility for the child) in a fee-for-service plan unless the State agency has established a special health service delivery system designated to customize and more efficiently provide health services to children in State-supervised care, in which case the State agency will enroll the child in the plan appropriate to ensure access to such a special health service delivery system.

(2) **CHILDREN IN STATE SUPERVISED CARE.**—For purposes of paragraph (1), the term “child in State-supervised care” means any child who is residing away from his or her parents and is temporarily or permanently, on a voluntary or involuntary basis, under the responsibility of a public child welfare or juvenile services agency or court. Such term includes children who are not yet made wards of the court or adjudicated as delinquents residing in emergency shelter care, children in the physical custody of public or private agencies, and children who are with foster parents, or other groups or residential care providers. Such term also includes children who are legally adopted and for whom the Federal or State government is providing adoption assistance payments.

Sec. 1013. Multiple employment situations

(a) **MULTIPLE EMPLOYMENT OF AN INDIVIDUAL.**—In the case of an individual who:

(1)(A) is not married or (B) is married and whose spouse is not a qualifying employee (as defined in Section 1901(b)(1)).

(2) Is not a child, and

(3) Who is a qualifying employee both of a community rate employer and of an experience rate employer (or of 2 large group sponsor employers), the individual may elect the applicable health plan to be either a community rated health plan (for the health care coverage area in which the individual resides) or an experience rated health plan (for an employer employing the individual).

(b) **MULTIPLE EMPLOYMENT WITHIN A FAMILY.**—

(1) **MARRIED COUPLE WITH EMPLOYMENT WITH A COMMUNITY RATE EMPLOYER AND WITH AN EXPERIENCE RATE EMPLOYER.**—In the case of a married individual:

(A) Who is a qualifying employee of a community rate employer and whose spouse is a qualifying employee of an experience rate employer, or

(B) Who is a qualifying employee of an experience rate employer and whose spouse is an qualifying employee of a community rate employer, the individual and the individual's spouse may elect the applicable health plan to be either a community rated health plan (for the health care coverage area in which the couple resides) or an experience rated health plan (for an employer employing the individual or the spouse).

(2) **MARRIED COUPLE WITH DIFFERENT EXPERIENCE RATED EMPLOYERS.**—In the case of a married individual

(A) Who is a qualifying employee of an experience rated employer, and

(B) Whose spouse is a qualifying employee of a different experience rate employer, the individual and the individual's spouse may elect the applicable health plan to be a experience rated health plan for an employer employing either the individual or the spouse.

Sec. 1014. Treatment of residents of States with Statewide single-payer systems.

(a) **UNIVERSAL COVERAGE.**—Notwithstanding the previous provisions of this title, except as provided in part 2 of subtitle C, in the case of an individual who resides in a State that has a Statewide single-payer system under Section 1223, universal coverage shall be provided consistent with Section 1222(3).

(b) **INDIVIDUAL RESPONSIBILITIES.**—In the case of an individual who resides in a single-payer State, the responsibilities of such individual under such system shall supersede the obligations of the individual under Section 1002.

SUBTITLE B. BENEFITS

Part 1. Comprehensive benefit package

Sec. 1101. Provision of comprehensive benefits by plans

(a) **IN GENERAL.**—Subject to the provisions of section 1603, the comprehensive benefit package shall consist of the following items and services (as described in this part), subject to the cost sharing requirements described in part 3, the exclusions described in part 4, and the duties and authority of the National Health Board described in part 5:

- (1) Hospital services (as described in section 1102).
- (2) Services of health professionals (as described in section 1103).
- (3) Emergency and ambulatory medical and surgical services (as described in section 1104).
- (4) Clinical preventive services (as described in section 1105).
- (5) Mental illness and substance abuse services (as described in section 1106).
- (6) Family planning services and services for pregnant women (as described in section 1107).
- (7) Hospice care (as described in section 1108).
- (8) Home health care (as described in section 1109).
- (9) Extended care services (as described in section 1110).
- (10) Ambulance services (as described in section 1111).
- (11) Outpatient laboratory, radiology, and diagnostic services (as described in section 1112).
- (12) Outpatient prescription drugs and biologicals (as described in section 1113).
- (13) Outpatient rehabilitation services (as described in section 1114).
- (14) Durable medical equipment, prosthetic devices, orthotics and prosthetics (as described in section 1115).
- (15) Vision care (as described in section 1116).
- (16) Hearing aids for children (as described in section 1117).
- (17) Dental care (as described in section 1118).
- (18) Investigational treatments (as described in section 1119).

(19) Optional services, such as: health education classes and extracontractual services (as described in section 1120).

(b) The items and services in the comprehensive benefit package shall not be subject to any duration or scope limitation or any deductible, copayment, or coinsurance amount that is not required or authorized under this Act.

Part 2. Cost sharing

Sec. 1131. Costing sharing

Each Health plan shall offer to individuals enrolled under the plan one, but not more than one, of the following cost sharing schedules, which schedule shall be offered to all such enrollees:

- (1) Lower cost sharing (described in section 1132).
- (2) Higher cost sharing (described in section 1133).
- (3) Combination cost sharing (described in section 1134).

For provisions relating to reducing cost sharing for certain low-income families, see section 1281.

The deductibles and out-of-pocket limits on cost sharing for a year under the schedules referred to in subsection (a) shall be applied based upon expenses incurred for items and services furnished in the year. The amount of the out of pocket limit described in subparagraph (A) is \$2,500 and in subparagraph (B) is \$3,000.

Sec. 1132. Lower cost sharing

(a) The lower cost sharing schedule referred to in section 1131 that is offered by a health plan:

(1) Shall have a deductible of \$250 per hospital admission, and shall not have any other required deductible;

(2) Except as provided in paragraph (4) shall prohibit payment of any coinsurance; and subject to section 1152, shall require payment of the copayment for an items or services as follows:

(i) For items and services described in sections 1101(a)(1), 1104, 1105, 1106(g)(1)(H), 1107, 1108, 1109, 1110, 1111, 1114, and for clinician visits and associated services related to prenatal care and 1 post-partum visit, no copayment is allowed.

(ii) For items and services described in sections 1101(a)(2), 1102, 1103, 1106 (subject to clause (i)), 1112, 1113, 1115, 1116, the copayment is \$10 per visit (or per prescription in the case of items described in section 1122);

(iii) For services described in section 1116(a)(4) and 1116(a)(5), the copayment is \$20 per visit;

(iv) For items and services described in section 1101(a)(3) and 1103, the copayment is \$25 per visit unless the patient has an emergency medical condition as defined in section 1867(e)(1) of the Social Security Act; and

(v) For items and services described in section 1119, all cost sharing rules shall be determined by plans.

(3) Shall require payment of coinsurance for an out-of-network item or service in an amount that is a percentage (as determined by the Board) of the applicable payment rate, but only if the item or service is subject to insurance under the

higher cost sharing schedule described in section 1133 or is a clinical preventive service as defined in section 1104.

Sec. 1133. Higher cost sharing

(a) The higher cost sharing schedule referred to in section 1131 that is offered by a health plan:

(1) Shall have an annual individual general deductible of \$200 and an annual family general deductible of \$400 that apply with respect to expenses incurred for all items and services in the comprehensive benefit package except—

(A) An item or service with respect to which a separate individual deductible applies under paragraph (2); or

(B) An item or service described in paragraph (3), (4), or (5) with respect to which a deductible does not apply,

(2) Shall require an individual to incur expenses in a year for outpatient prescription drugs and biologicals (described in section 1113) equal to \$250 before the plan provides benefits for such items to the individual;

(3) Shall require an individual to incur expenses in a year for dental care described in section 1118, except the items and services for prevention and diagnosis of dental disease described in section 1118(a)(2), equal to \$50 before the plan provides benefits for such care to the individual;

(4) May not require any deductible for clinical preventive services (described in section 1105);

(5) May not require any deductible for family planning services as defined in section 1107(1), clinician visits and associated services related to prenatal care or 1 post-partum visit under section 1107;

(6) May not require any deductible for the items and services for prevention and diagnosis of dental disease described in section 1118(a)(2);

(7) Shall prohibit payment of any copayment; and

(8) Subject to section 1152, shall require payment of the coinsurance for an item or service as follows:

(A) For items and services described in section 1105, family planning services and clinical visits and associated services related to prenatal care and one post partum visit and case management services under section 1106, no coinsurance is permitted.

(B) For items and services described in section 1118(a)(4) and 1118(a)(5), the coinsurance in 40 percent of the applicable payment rate;

(C) For outpatient services under section 1106—

(i) The coinsurance with respect to the first five outpatient psychotherapy visits is 20 percent of the applicable payment rate;

(ii) The coinsurance with respect to any subsequent outpatient psychotherapy visits is 50 percent of the applicable payment rate; and

(iii) The coinsurance with respect to children for outpatient psychotherapy visits is 20 percent of the applicable payment rate; and

(D) For all other items and services, the coinsurance is 20 percent of the applicable payment rate.

For purposes of this section "applicable payment rate", when used with respect to an item or service, means the applicable payment rate for the item or service established under section 1523(e).

Sec. 1134. Combination cost sharing

(a) The combination cost sharing schedule referred to in section 1131 that is offered by a health plan shall require different cost sharing for in-network items and services than for out-of-network items and services.

(b) **IN-NETWORK ITEMS AND SERVICES.**—With respect to an in-network item or service (as defined in section 1514), the combination cost sharing schedule that is offered by a health plan

(1) shall have a deductible of \$250 per hospital admission, and shall not have any other required deductible;

(2) shall prohibit payment of any coinsurance; and

(3) shall require payment of a copayment in accordance with the lower cost sharing schedule described in section 1132.

(c) With respect to an out-of-network item or service (as defined in section 1514), the combination cost sharing schedule that is offered by a health plan

(1) shall require an individual and a family to incur expenses before the plan provides benefits for the item or service in accordance with the deductibles under the higher cost sharing schedule described in section 1133;

(2) shall prohibit payment of any copayment; and

(3) shall require payment of coinsurance in accordance with such schedule, except with regard to clinical preventive services obtained out of network that shall be subject to a coinsurance percentage as determined by the National Board under section 1132.

Sec. 1135. Indexing dollar amounts relating to cost sharing

(a) Any deductible, copayment, out-of-pocket limit on cost sharing, or other amount expressed in dollars in this subtitle for items or services provided in a year after 1994 shall be such amount increased by the percentage specified in subsection (b) for the year and for each previous year after 1994, minus 1. Any increase or decrease under this section shall be rounded.

(b)(1) The factor described in this subsection for a year is 1 plus the general health care inflation factor (as specified in section 6001(a)(3) and determined under paragraph (2)) for the year.

(2) In computing such factor for a year, the percentage increase in the CPI for a year (referred to in section 6001(b)) shall be determined based upon the percentage increase in the average of the CPI for the 12-month period ending with August 31 of the previous year over such average for the preceding 12-month period.

Part 3. Exclusions

Sec. 1141. Exclusions

(a) The comprehensive benefit package does not include:

(1) an item or service that is not medically necessary or appropriate; or

(2) an item or service that the National Health Board may determine is not medically necessary or appropriate in a regulation promulgated under section 1154.

(b) **ADDITIONAL EXCLUSIONS.**—The comprehensive benefit package does not include the following items and services:

(1) Custodial care, except in the case of hospice care under section 1107.

(2) Surgery and other procedures performed solely for cosmetic purposes and hospital or other services incident thereto, unless—

(A) required to correct a congenital anomaly; or

(B) required to restore or correct a part of the body that has been altered as a result of accidental injury; disease; or surgery that is otherwise covered under this subtitle.

(3) Hearing aids, except as provided in section 1117.

(4) Eyeglasses and contact lenses for individuals at least 18 years of age.

(5) In vitro fertilization services.

(6) Sex change surgery and related services.

(7) Private duty nursing.

(8) Personal comfort items, except in the case of hospice care under section 1107.

(9) Any dental procedures involving orthodontic care, inlays, gold or platinum fillings, bridges, crowns, pin/post retention, dental implants, surgical periodontal procedures, or the preparation of the mouth for the fitting or continued use of dentures, except as specifically described in section 1118.

Part 4. Role of the National Health Board

Sec. 1151. Definition of benefits

The National Health Board may promulgate such regulations or establish such guidelines as may be necessary to assure uniformity in the application of the comprehensive benefit package across all health plans. Such regulations or guidelines shall permit a health plan to deliver covered items and services to individuals enrolled under the plan using the providers and methods that the plan determines to be appropriate.

Sec. 1152. Acceleration of expanded benefit

(a) Subject to subsection (b), at any time prior to January 1, 2001, the National Health Board, in its discretion, may by regulation expand the comprehensive benefit package by adding any item or service that is added to the package as of January 1, 2001; and requiring that a cost sharing schedule described in part 3 of this subtitle reflect (wholly or in part) any of the cost sharing requirements that apply to the schedule as of January 1, 2001. No such expansion shall be effective except as of January 1 of a year.

(b) The board may not expand the benefit package under subsection (a) which is to become effective with respect to a year, by adding any item or service or altering any cost sharing schedule, unless the Board estimates that the additional increase in per cap-

ita health care expenditures resulting from the addition or alteration, for each health care coverage area for the year, will not cause any to exceed its per capita target (as determined under section 6003).

Sec. 1153. Authority with respect to clinical preventive services

(a) With respect to clinical preventive services described in section 1104, the National Health Board

(1) shall specify and define specific items and services as clinical preventive services for high risk populations within 1 year of the date of enactment of this act and shall establish and update a periodicity schedule for such items and services;

(2) shall establish and update the periodicity schedules for the age-appropriate immunizations;

(3) shall establish a periodicity schedule for the age-appropriate tests and clinician visits for individuals under the age of 20;

(4) shall establish rules with respect to coverage for an immunization, test, or clinician visit that is not provided to an individual during the age range for such immunization, test or clinician visit that is specified in such section; and

(5) may otherwise modify the items and services described in such section, taking into account age and other risk factors, but may not modify the cost during for any such item or service.

(b) In performing the functions described in subsection (a), the National Health Board shall consult with experts in clinical preventive services, including those specified in section 1105.

Sec. 1154. Establishment of standards regarding medical necessity.

The National Health Board may promulgate such regulations as may be necessary to carry out section 1141(a)(2) (relating to the exclusion of certain services that are not medically necessary or appropriate).

Sec. 1155. Balance billing

The Board shall provide for methods to ensure the prohibition of balance billing.

Part 5. Additional provisions relating to health care providers

Sec. 1161. Override of restrictive State practice laws

No State may, through Licensure or otherwise, restrict the practice of any class of health professionals beyond what is justified by the skills and training of such professionals.

Sec. 1162. Provision of items or services contrary to religious belief or moral conviction

A health professional or a health facility may not be required to provide an item or service in the comprehensive benefit package if the professional or facility objects to doing so on the basis of a religious belief or moral conviction.

Sec. 1163. Duty to disclose incorrect test results

(a) Any facility, including hospitals, clinics, and clinical laboratories, which provides diagnostic testing of other health care items or services covered under this Act shall promptly notify the individual provider who ordered the test of any errors in the test results. The individual provider who ordered the test must promptly notify the patient of the error if the new results affect the patient's diagnosis or treatment.

(b) To carry out subsection (a), the Secretary shall promptly issue proposed regulations, and within 9 months of the date of enactment of this act shall issue final regulations.

SUBTITLE C. STATE RESPONSIBILITIES

This subtitle sets forth general requirements for participating States and provides special rules for States administering single payer programs.

Sec. 1200. Participating State

(a) A State is a participating State if it meets the requirements of this subtitle.

(b) States that elect to participate must have an approved system in place by January 1, 1998. In States that do not elect to participate, the provisions of subpart C of part 1 of subtitle F (relating to Federal operation) take effect. A State becomes a participating State if it submits its system for approval by the National Health Board and the Board approves the State's health care system.

Participating States must submit annual updates to the Board by February 15 of each year after the first year a State has been approved. Annual updates must consist of such information as the Board requires to determine whether a State health care system meets the requirements of the Health Security Act in the year for which the update is submitted, and whether a State system was operated as approved by the Board during the preceding year.

Part 1. General State responsibilities

Sec. 1201. General State responsibilities

Participating States are responsible for:

- (1) Establish one or more health care coverage areas, in accordance with section 1202;
- (2) Certify health plans and overseeing health plans, in accordance with subtitle F;
- (3) Meeting certain requirements for operating health profession boards;
- (4) Administering risk adjustment, reinsurance, and other premium adjustment programs consistent with the act;
- (5) Administering reductions in cost-sharing in accordance with sections 1281 and 1282 and a premium discount program as required under subtitle B of title VI;
- (6) Certification of at least one consumer purchasing cooperative in each area; and
- (7) Carry out other responsibilities of participating States under the act.

Sec. 1202. Assuring community-rated premiums through establishment of health care coverage areas

A State must establish health care coverage areas within the State meeting requirements under this section, including no overlapping of coverage areas, no division of metropolitan statistical areas, establishing areas of at least 150,000 population, and compliance with antidiscrimination rules in establishing coverage areas.

Sec. 1203. Use of incentives

A State may provide incentives to health plans to enroll members of disadvantaged groups, to provide appropriate extra services to such groups, and to encourage plans to serve or new plans to develop to serve underserved areas.

Sec. 1204. Restrictions on the funding of additional benefits

A State may not use funds provided under this act to pay for benefits in addition to those provided through the guaranteed benefit package.

Sec. 1205. Consumer information and marketing

Each State must assure the availability of information allowing individuals to make comparisons among health plan, including a summary of the annual quality performance report under 5005(c)(1), and ensure that health plans meet marketing requirements under section 1515.

Sec. 1206. State responsibilities with respect to worksite health promotion discounts

A State shall provide for the administration of such discounts.

Sec. 1207. Consumer advocate

The Secretary shall establish a National Center for Consumer Advocacy and an Office of Consumer Advocacy in each State. These State offices shall provide assistance to consumers, including outreach and education relating to consumer rights and responsibilities, assistance with enrollment in health plans and application for subsidies, and provision of information and assistance in resolving enrollee grievances.

Sec. 1208. Election procedure for community-rated employers

Each State shall establish a procedure for exempt employers, as defined in section 6117, to elect to be treated as a community-rated employer.

Sec. 1209. Coordinated services for children

The State shall designate an agency, which shall assist in coordination of delivery of medical and social services to children.

Sec. 1210. State responsibilities for utilization management

The State shall certify or recertify a health plan only if it meets standards for utilization management, including prohibition of contract terms requiring, limiting medically necessary service, disclosure of utilization management protocols and financial incentives

for controlling utilization, consistent application of protocols, and availability of utilization managers for preauthorizations and other purposes.

Sec. 1211. Assuring family choice of health plans

A participating State shall ensure that all community-related individuals have a choice of health plans, including at least one fee-for-service plan.

Sec. 1212. Oversight of health plan enrollment activities

Each State shall provide for general oversight of health plan enrollment activities, a mechanism for enrolling through providers for unenrolled individuals seeking services, and penalties for failure to enroll.

Sec. 1213. Administration of allowance percentage

The State shall establish an administrative allowance percentage to be included in plan premiums for administrative functions of the State, not to exceed 1.5 percent.

Part 2. Requirements for State single payer systems

Sec. 1221. Single payer system described

The National Board is required to approve a State's application to administer a single payer system if the State's application either meets the requirement for a statewide single payer system or for a single payer system offered in a health care coverage area of a State.

Sec. 1222. General requirements for single payer systems

Each State single payer system must meet the following requirements:

(1) The system is established under State law and the State law provides mechanisms to enforce its plan requirements.

(2) The system is operated by a State agency.

(3) The State system provides for enrollment of all persons who are community-rate eligible individuals, including enrollment of all Medicare eligible individuals if the State has received approval from the Secretary of HHS for Medicare integration and enrollment of all experience-rated individuals, if the State has elected to do so. Single payer States may not require enrollment of electing veterans, electing Indians or active duty military personnel.

(4) The State makes direct payments to providers and assumes all financial risk (although payments per capita with the assumption of financial risk by providers is permitted).

(5) The State provides the comprehensive benefit package to all persons and maintains cost sharing requirements no greater on any subgroup of individuals than those permitted under the act.

(6) The State maintains per capita expenditures within the target established by the Board and has mandatory enforcement mechanisms to reduce payments to health care providers

to assure that per capita expenditures do not exceed applicable targets.

(7) The State meets all requirements applicable to health plans under Section 1502(1) but does not limit enrollment based on capacity. Requirements for plans relating to marketing and plan solvency do not apply.

Sec. 1223. Special rules for States operating statewide single payer systems

(a) States operating statewide single payer systems are required to operate the system throughout the State and must meet the basic requirements for participating States.

(b) Certain requirements otherwise applicable are waived.

(c) Rules pertaining to enrollment and issuance of Health Security cards continue to apply. Similarly, rules pertaining to low income assistance, nondiscrimination, and data collection and quality assurance continue.

(d) A State using a single payer system must at least in part use a payroll-based financing system that requires employers to pay at least as much as they would be required to pay under normal rules of operation in nonsingle payer States.

Sec. 1224. Special rules for health care coverage area-specific single-payer systems

(a) A State operating such a system must comply with the rules applicable to participating States.

(b) Each system must meet requirements generally applicable to health care coverage areas, except that such system does not have to comply with the plan choice or contract with health plan requirements and does not have the authority to use financial incentives to stimulate service by plans in areas with inadequate services.

Part 3. Reductions in cost sharing and premiums

This part sets out the requirements for cost sharing and premium reductions for low income families and the State's responsibility in administering such programs.

Sec. 1281. Reduction in cost sharing and premiums

Families receiving AFDC or SSI or with family incomes below 200 percent of poverty are entitled to cost-sharing reductions administered by the State.

If no low or combination cost-sharing plan is available in the area at or below the average priced plan, families receiving AFDC or SSI or with incomes below 150 percent of poverty are eligible for cost-sharing reductions to bring their cost-sharing down to the level that would have been available under such a plan.

Families enrolled in AFDC or SSI or with incomes below 100 percent of poverty are eligible for a further cost-sharing reduction to 20 percent of the level that would be otherwise payable. Families between 100–150 percent of poverty are eligible for a further cost-sharing reduction to 40 percent of the level normally applicable.

Families with incomes 150–200 percent of poverty are eligible for a cost-sharing reduction to 40 percent of the otherwise applicable amount.

Sec. 1282. Application process for cost-sharing reductions and premium discounts

Families may apply to the State for cost-sharing reductions and premium discounts. States must act on applications in a timely manner, shall ensure adequate distribution of application materials, and must provide assistance to individuals.

The State shall verify eligibility of individuals for discounts and cost-sharing reductions and each family shall notify the State of changes in its status.

Penalties are provided for inaccurate information. AFDC and SSI recipients are not required to submit an application.

Sec. 1283. Provides for an end-of-year reconciliation of under or overpayment of discounts to families based on final statement of income for the year

Sec. 1284. States must maintain error rates below an applicable maximum specified by the Secretary or Secretary of Labor

SUBTITLE D. CONSUMER PURCHASING COOPERATIVES

Part 1. General requirements

Sec. 1301. Designation and organization of cooperatives

A State shall certify consumer purchasing cooperatives. Each cooperative shall be operated as a not-for-profit corporation governed by a Board of Directors meeting certain requirements. All eligible employers and individuals shall be accepted as members of a cooperative. Each cooperative shall enter into agreements with health plans and community-rated employers, enroll eligible individuals in health plans, make payments to health plans on behalf of enrollees, and carry out other responsibilities. A cooperative shall not perform any activity related to payment rates for providers, enforce compliance with the act with regard to health plans, assume insurance risk, or perform other activities identified by the State as being inconsistent with the performance of its duties under the act.

Participation in cooperatives is voluntary, and a State may designate or establish more than one cooperative per area.

Sec. 1302. Agreements with health plans

Each cooperative shall enter into agreements with each certified health plan, unless the cooperative is designated as a "negotiating cooperative" by the State and it is the sole State-certified cooperative in the health care coverage area.

Plans shall be offered at the community rate, except that a negotiating cooperative may offer the plan at a lesser rate.

Sec. 1303. Agreements with community-rated employers

Cooperatives shall offer to enter into an agreement with each community-rated employer. Qualified employees may elect to enroll in a plan offered through a cooperative with which the employee has an agreement, with a plan offered directly through the employer, or with a plan offered by the FEHBP.

Sec. 1304. Enrolling individuals in health plans through a cooperative

Each cooperative shall establish an enrollment process in accordance with rules established by the Board which allows any community-rate individual to enroll with any plan offered by the cooperative.

Sec. 1305. Cooperative fee

Each cooperative shall charge members a uniform membership fee to cover administrative expenses of the cooperative, and cooperatives may compete on the basis of such fees.

Sec. 1306. Coordination among cooperatives

The State shall establish rules consistent with this section for coordination among cooperatives.

Sec. 1307. Third-party contracting to perform duties

Each cooperative may contract with independent third parties for services. Conflicts of interest are prohibited.

Part 2. Access to health plans sponsored by FEHBP

Sec. 1321. Designation of FEHBP as a purchasing cooperative

The FEHBP shall serve as a consumer purchasing cooperative in each health care coverage area designated by each State.

Sec. 1322. Special rules for FEHBP supplemental plans

Requires the Office of Personnel Management to develop FEHBP supplemental health benefit policies and to offer such supplemental health benefit policies, and cost sharing policies as provided in section 1523, to Federal employees, annuitants, and any other community-rate eligible individuals. Provides that OPM shall meet and confer with representatives of Federal employees regarding the supplemental health benefit policies and cost sharing policies to be offered (and premium contributions, if any, to be made by the Federal Government with respect to such policies for Federal employees and annuitants) through a process to be established by the National Partnership Council.

Sec. 1401. Definitions

(a) **LARGE GROUP PURCHASER DEFINED.**—In this act, the term “large group purchaser” means an employer that is a current large employer (as defined in subsection (e)(2)), or a dual choice employer (as defined in subsection (e)(4)) that has elected to become a large employer, and is not an excluded employer described in subsection (b)(2); or is an eligible purchaser (described in subsection (b)) if:

(1) the sponsor elects, in a form and manner specified by the Secretary of Labor consistent with this subpart, to be treated as a large group purchaser under this title and such election has not been terminated under section 1403; and

(2) the purchaser has filed with the Secretary of Labor a document describing how the sponsor shall carry out activities as such a large group purchaser consistent with part 2.

(b) **ELIGIBLE LARGE GROUP PURCHASER.**—(1) Each of the following is an eligible large group purchaser:

(A) **NEW LARGE EMPLOYER.**—An employer that is a new large employer (as defined in subsection (e)(2)) as of the date of an election under subsection (a)(1), and is not an excluded employer described in paragraph (2).

(B) A plan sponsor described in Section 3(16)(b)(iii) of Employee Retirement Income Security Act of 1974, but only with respect to a group health plan that is a multiemployer plan (as defined in subsection (e)(3) maintained by the sponsor and only if such plan offered health benefits as of September 1, 1993, and as of both September 1, 1993, and January 1, 1996, such plan covers more than 1,000 full-time employees in the United States, or the plan is maintained by one or more affiliates of the same labor organization, or one or more affiliates of labor organizations representing employees in the same industry, covering more than 1,000 employees.

(2) Each of the following are excluded employers described in this paragraph:

(A) An employer whose primary business is employee leasing.

(B) The Federal government (other than the U.S. Postal Service).

(c) **INDIVIDUALS ELIGIBLE TO ENROLL.**—Each eligible individual who is a full-time employee (as defined in section 1901(b)(2)(C)) of a current large employer, or a new large employer that has an election in effect as a large group purchaser, is eligible to enroll in an experience-rated plan offered by such purchaser.

Each participant and beneficiary (as defined in subparagraph (B)) under a multiemployer plan, with respect to which an eligible purchaser of the plan described in subsection (b)(1)(B) has an election in effect as a large group purchaser, is eligible to enroll in an experience-rated plan offered by such purchaser.

Except as provided in section 1013, an experience-rated individual is not eligible to enroll under a community-rated plan.

(d) **EXCLUSION OF CERTAIN INDIVIDUALS.**—In accordance with rules of the Board, the following individuals shall not be treated as experience-rated individuals:

(1) AFDC recipients.

(2) SSI recipients.

(3) Individuals who are described in section 1004(b) (relating to veterans, military personnel, and Indians) and who elect an applicable health plan described in such section.

(4) Employees who are seasonal or temporary workers (as defined by the Board), other than such workers who are treated as experience-rated individuals pursuant to a collective bargaining agreement (as defined by the Secretary of Labor).

(5) Electing migrant and seasonal agricultural workers (described in section 1005(b)(4)).

(c) Additional definitions used in this subtitle include the following:

(1) **GROUP HEALTH PLAN.**—The term “group health plan” means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974)

providing medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) to participants or beneficiaries (as defined in section 3 of the Employee Retirement Income Security Act of 1974) directly or through insurance, reimbursement, or otherwise.

(2) **LARGE EMPLOYER.**—The term “large employer” means an employer with more than 1,000 full-time employees in the United States. Such term includes the United States Postal Service.

(3) **SMALL EMPLOYER.**—The term “small employer” means an employer with 500 or less full-time employees.

(4) **DUAL CHOICE EMPLOYER.**—The term “dual choice employer” means an employer with more than 500 but less than 1,000 full-time employees. A dual choice employer may elect to be considered as either a small employer or a large employer for purposes of this act. A dual choice employer electing to be a large employer shall not be eligible for discounts under title VI.

(5) **EMPLOYER SPONSORED HEALTH PLAN.**—The term “employer sponsored health plan” means a group health plan with an enrollment of at least 500 individuals that is established and maintained by a large employer. The employer shall retain the insurance risk and meet requirements specified by the Secretary of Labor for such plans in accordance with section 1406. The Secretary shall ensure that employer sponsored health plans meet the requirements of this paragraph.

(6) **MULTIEMPLOYER PLAN.**—The term “multiemployer plan” has the meaning given such term in section 3(37) of the Employee Retirement Income Security Act of 1974, and includes any plan that is treated as such a plan under title I of such act.

Sec. 1402. Election of large group purchasers

The Secretary of Labor shall promulgate regulations for the election of new large employers and multiemployer plans as large group purchasers. If the number of full-time employees of a dual choice employer changes during the coverage year such that the employer has fewer than 500 or more than 1,000 employees, the status of such employer shall be retained only throughout that year.

Sec. 1403. Employee enrollment requirement

(a) **ESTABLISHMENT OF EMPLOYER ENROLLMENT FUNCTION.**—(1) Each employer shall make available enrollment in at least three health plans, one of which shall be a fee-for-service plan, to each eligible employee of such employer.

(2) **LARGE GROUP PURCHASERS.**—Each large group purchaser shall satisfy the requirement above and ensure that each eligible individual is enrolled in a health plan and receives continuous coverage pursuant to regulations promulgated by the Secretary of Labor and consistent with the appropriate provisions of subtitle F.

(3) **SMALL EMPLOYERS.**—Each small employer shall offer, at the age-adjusted community rate in the area, at least three State-certified health plans, one of which shall be a fee-for-service plan, and

shall join a consumer purchasing cooperative. A small employer may satisfy the requirement that it offer at least three health plans by joining a consumer purchasing cooperative.

(b) **FORWARDING OF ENROLLMENT INFORMATION.**—(1) **INFORMATION REGARDING PLANS.**—An employer must provide each employee of such employer with information regarding all qualified health plans offered in the health care coverage area in which the employer is located and, if the employee resides in another health care coverage area, information regarding how to obtain information on qualified health plans offered to residents of such other health care coverage area.

(2) **INFORMATION REGARDING EMPLOYEES.**—An employer must forward the name and address (and any other necessary identifying information specified by the Secretary) of each eligible employee to the qualified health plan in which such employee is enrolled, or to the cooperative (if any) through which such enrollment is made.

(c) **PAYROLL DEDUCTION.**—The employer, upon authorization by the employee, shall provide for the deduction, from the employee's wages or other compensation, of the premium amount due (less any employer contribution) to the plan or purchasing group in accordance with section 6209.

(d) **NO REQUIREMENT TO ENROLL IN EMPLOYER-PROVIDED PLAN.**—An eligible employee of a community-rated employer may elect not to enroll in a health plan offered by an employer under this section.

Sec. 1404. Responsibilities and authority of employer purchasers

(a) **ELECTIONS BY EMPLOYEES.**—Each employer shall make the selections of health plans under this subsection on an annual basis. In making each such selection, an employer shall comply with any selection made by at least 50 percent of the eligible employees of the employer. The Secretary of Labor shall prescribe rules which shall govern the manner in which employees may make such a selection.

(b) **SPECIFIC REQUIREMENTS OF LARGER GROUP PURCHASERS.**—(1) **CONTRACTS WITH PLANS.**—Each large group purchaser may negotiate with a State certified health plan to enter into a contract with the plan for the enrollment of such individuals under the plan; or offer to individuals an appropriate employer sponsored health plan (as defined in section 1401(e)(5)).

(2) **TERMS OF CONTRACTS WITH STATE-CERTIFIED HEALTH PLANS.**—Contracts under this Section between a large group purchaser and a State-certified health plan may not remove the obligation of the large group purchaser to provide for health benefits to large group purchaser eligible individuals consistent with this part.

(3) **PLAN AND INFORMATION REQUIREMENTS.**—A large group purchaser shall provide a written submission to the Secretary of Labor (in such form as the Secretary may require) detailing how the large group purchaser will carry out its activities under this part. It shall also provide to the Secretary of Labor each year such information as the Secretary may require in order to monitor the compliance of the purchaser with the requirements of this part.

(4) **MANAGEMENT OF FUNDS.**—The management of funds by any large group purchaser shall be subject to the applicable fiduciary requirements of part 4 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, together with the applicable enforcement provisions of part 5 of subtitle B of title I of such act. Each large group purchaser shall comply with standards relating to the management of finances and records and accounting systems as the Secretary of Labor shall specify.

(c) **LARGE GROUP PURCHASER TRANSITION.**—Each large group purchaser must provide coverage.—(1) As of the first day of any month in which an individual first becomes a large group sponsor eligible individual, and

(2) Through the end of the month in the case of a large group sponsor eligible individual who loses such eligibility during the month unless covered under paragraph (1).

(d) **EMPLOYEE SHARE.**—The premiums charged by a large group purchaser to an employee for enrollment in a plan offered by such a purchaser (not taking into account any employer premium payment under section 6131) shall vary only by class of family enrollment (as specified under section 6131) and by geographic area.

Sec. 1405. Development of large employer group purchasers

Nothing in this title shall be construed as prohibiting 2 or more large employers from forming a purchasing group with respect to the employees of such employer or employers. Such entities shall comply with the requirements applicable to health plans offered by large group purchasers under this subtitle. A large employer shall be ineligible to purchase health insurance through an individual and community-rated employer purchasing cooperative.

Sec. 1406. Timing and termination of employer elections

The Secretary of Labor shall promulgate regulations for employer elections. A large group sponsor (other than a large employer) may terminate an election by filing a notice of intent to terminate with the Secretary.

Part 2. Requirements for health plans offered by large group purchasers

Sec. 1411. Establishment of standards applicable to employer sponsored plans

The Secretary of Labor shall develop and publish standards applicable to employer sponsored plans (as defined in section 1401(e)(5)) offered by large group purchasers. These requirements include:

(a) Applicable plan requirements specified in subtitle F.

(b) Standards relating to financial solvency, reserve and guaranty fund requirements that the Secretary of Labor shall specify, except that such standards shall be consistent with the applicable rules under part 4 of title I of the Employee Retirement Income Security Act of 1974;

(c) Requirements relating to the payments of premiums; and

(d) Requirements relating to claims grievance procedures, in accordance with subtitle C of title V.

The Secretary shall develop and publish such standards by not later than the date that is 6 months after the date of enactment of this act. Such standards shall be the certified health plan standards applicable to employer sponsored plans under this part.

Sec. 1412. Corrective actions for health plans offered by large employers

The plan sponsor of each large employer plan shall determine semiannually whether the requirements of this part are met. In any case in which the plan sponsor determines that there is reason to believe that there is or will be a failure to meet such requirements, or the Secretary of Labor makes such a determination and so notifies the plan sponsor, the plan sponsor shall notify such Secretary of a description of the corrective actions (if any) that the plan sponsor has taken or plans to take in response to such recommendations. The plan sponsor shall thereafter report to such Secretary regarding corrective action taken by the plan sponsor until such requirements are met.

In any case in which the plan sponsor of a large employer plan determines that there is reason to believe that the plan will cease to be a large employer sponsored health plan or will terminate, the plan sponsor shall so inform the Secretary of Labor, shall develop a plan for winding up the affairs of the plan in connection with such disqualification or termination in a manner which will result in timely payment of all benefits for which the plan is obligated, and shall submit such plan in writing to such Secretary. The sponsor shall also adhere to certain actions in connection with disqualification or termination.

Sec. 1413. Disclosure and reserve requirements for large employer purchaser health plans

(a) The Secretary of Labor shall ensure that each large group purchaser health plan which is an employer sponsored health plan maintains plan assets in trust as provided in section 403 of the Employee Retirement Income Security Act of 1974.—(1) Without any exemption under section 403(b)(4) of such act, and

(2) In amounts which the Secretary determines are sufficient to provide at any time for payment to health care providers of all outstanding balances owed by the plan at such time and consistent with standards for State certified health plans.

(b) Each employer sponsored health plan shall notify the Secretary at such time as the financial reserve requirements of this section are not being met. The Secretary may assess a civil money penalty of not more than \$100,000 against any large group purchaser for any failure to provide such notification in such form and manner and within such time periods as the Secretary may prescribe by regulation.

Sec. 1414. Trusteeship by the secretary of insolvent large employer purchased health plans

(a) Whenever the Secretary of Labor determines that a large employer sponsored health plan is in a financially hazardous condition, the Secretary shall apply to the appropriate United States district court for appointment of the Secretary as trustee to admin-

ister the plan for the duration of the insolvency. The court shall appoint the Secretary trustee if the court determines that the trusteeship is necessary to protect the interests of the enrolled individuals or health care providers.

(b) **POWERS AS TRUSTEE.**—The Secretary of Labor, upon appointment as trustee under subsection (a), shall have the power to do any act authorized by the plan, this Act, or other applicable provisions of law to be done by the plan administrator or any trustee of the plan and as other authorities.

(c) **NOTICE OF APPOINTMENT.**—As soon as practicable after the Secretary's appointment as trustee, the Secretary shall give notice of such appointment to appropriate parties.

(d) **ADDITIONAL DUTIES.**—Except to the extent inconsistent with the provisions of this act or part 4 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, or as may be otherwise ordered by the court, the Secretary of Labor, upon appointment as trustee under this section, shall be subject to the same duties as those of a trustee under section 704 of title 11, United States Code, and shall have the duties of a fiduciary for purposes of such part 4.

SUBTITLE F. HEALTH PLANS

Sec. 1500. Health plan defined

Defines a health plan as a plan meeting the requirements of the act. A State-certified health plan is a health plan certified by the State.

Part I. Requirements for health plans

Sec. 1501. Qualified health plans.

To be certified, a health plan must meet the applicable standards under section 1503. Health plans offered by large group purchasers shall meet applicable standards in accordance with subtitle E.

Sec. 1502. Application of requirements.

No plan shall be treated under the act as a health plan unless the plan is a self-insured plan or a state-certified plan.

Sec. 1503. Establishment of standards.

In order to be certified, a plan must meet the requirements of the act, as described in regulations promulgated by the Secretary, including standards requiring that the plan shall provide for effective delivery of covered services throughout each designated services area for which it is certified, provide for coverage of the comprehensive benefit package described in subtitle B, provide for the collection and reporting of data, not discriminate in enrollment or benefits, establish community-rated premiums for the comprehensive benefits, meet financial solvency and financial management standards promulgated by the Board, provide for effective grievance procedures, demonstrate an ability to ensure that enrollees have adequate access to providers of health care, meet information, disclosure and marketing requirements, meet requirements for open enrollment, availability, and renewability, meet requirements with respect to rural and underserved areas, meet requirements with re-

spect to participation in a payment adjustment program, meet quality standards, enter into agreements with cooperatives, and meet other applicable requirements of this act.

Sec. 1504. Certification and revocation of health plan certification.

A participating State shall certify each health plan, review the continued compliance of each health plan with requirements, and recertify plans not less frequently than once in every 3 year period. The State may revoke certification only if the State determines the plan no longer meets the requirement for certification.

Sec. 1505. Monitoring.

The State shall monitor the performance of each state-certified plan.

Sec. 1506. Association health plans

An association health plan shall either meet the requirements of a State-certified community-rated health plan or a State-certified consumer purchasing cooperative.

Sec. 1507. Specified standard benefits; supplemental benefits; and cost-sharing policies

A health plan must offer the comprehensive benefit package specified under the act. A plan may offer supplemental health insurance policies meeting the requirements of this section if certified by the State and meeting requirements established by the Board.

Sec. 1508. Collection, provision of standardized information, and confidentiality

Each health plan must provide information required in accordance with subtitles A and B of title V.

Sec. 1509. Prohibition of discrimination.

Each plan shall comply with antidiscrimination provisions established under section 1914 and this section.

Sec. 1510. Quality assurance standards

Each health plan shall comply with plan performance standards in accordance with subtitle A of title V and meet internal quality standards under this section.

Sec. 1511. Community-rating

The Secretary shall promulgate regulations for community-rating as modified by age, with age-adjustments to terminate on December 31, 1998. Plans may impose a marketing fee for individuals enrolling through an agent.

Sec. 1512. Financial solvency requirements and consumer protection against provider claims

Health plans must meet financial solvency requirements. Individuals shall not be responsible to providers for failure of plan to pay health claims.

Sec. 1513. Grievance procedures

A plan must establish grievance procedures in accordance with subtitle C of title V.

Sec. 1514. Access to care

(a) Each low-cost sharing health plan shall offer enrollees a separately priced point-of-service option consistent with regulations of the Secretary the opportunity to obtain coverage for out-of-network items and services, except that such point-of-service option must be offered, and priced separately from the benefits offered through the plan's network. A health plan providing coverage to an enrollee for out-of-network items and services may charge an alternative premium and require alternative cost-sharing to take into account such coverage consistent with regulations promulgated by the Secretary.

(b) Each health plan, in providing benefits in the comprehensive benefit package shall include in its payments to providers such additional reimbursement as may be necessary to reflect cost sharing reductions to which individuals are entitled under section 1281.

The term "in-network" means items or services provided to an individual enrolled under a health plan by a health care provider who is a member of a provider network of the plan.

The term "out-of-network" means items or services provided to an individual enrolled under a health plan by a health care provider who is not a member of a provider network of the plan.

The term "provider network" means, with respect to a health plan, providers who have entered into an agreement with the plan under which such providers are obligated to provide items and services in the comprehensive benefit package to individuals enrolled in the plan, or have an agreement to provide services on a fee-for-service basis.

The term "network plan" means a health plan that utilizes a provider network, and meets the requirements of section 1523(c).

Sec. 1515. Information and marketing standards

Information and marketing standards. Plans must meet standards for marketing and advertising established by the state and this section and must provide information in accordance with sections 1205 and 1603(e). Standards are established for agents' commissions. Appropriate materials must be provided for non-English speakers.

Sec. 1516. Enrollment, availability and renewability

Sets standards for renewal and enrollment. No plan may engage in any practice that has the effect of attracting or limiting enrollees on the basis of personal characteristics. No limits on coverage other than those provided in the standard benefit package of preexisting condition exclusions of waiting periods are permitted. Standards or set forth for dealing with limitations on enrollment as the result of limited capacity, geographic enrollment responsibilities of network plans, and voluntary terminations of plans.

Sec. 1517. Administrative provisions

Each plan shall demonstrate to the certifying authority its administrative capacity and that it has an appropriate utilization management process.

Sec. 1518. Information requiring a patient's right to self-determination in health care services

Provides for advance directives.

Sec. 1519. Rural and medically undeserved areas

Allows special provisions for medically undeserved areas.

Sec. 1520. Payment adjustment

Each plan shall participate in any risk adjustment, reinsurance or other premium adjustment program implemented by the State in accordance with section 1641. Provisions regarding risk adjustment and reinsurance shall not apply to health plans offered by large group purchasers.

Sec. 1521. Pre-emption of certain state laws relating to health plans

Pre-empts certain state laws relating to health plans, including laws prohibiting plans from limiting the number and type of health care providers participating in the plan, establishing different rates for participating and nonparticipating providers, and creating incentives to encourage the use of participating providers. Certain State laws prohibiting the corporate practice of medicine are pre-empted.

Sec. 1522. Contracts with consumer purchasing cooperatives

A certified health plan shall enter into contracts with each cooperative wishing to enter into a contract. No health plan may charge enrollees in a cooperative more than its community rate.

Sec. 1523. Health plan arrangements with providers

Establishes rules for health plan arrangements with providers, including: verifying credentials of providers and overseeing the performance of participating providers; having arrangements with a sufficient number and types of providers to ensure the provision of services; assuring that any arrangements with gatekeepers provide for appropriate use of specialists if medically appropriate; assuring continued care without prior gatekeeper approval for each visit to relevant specialists for persons with chronic diseases; assuring access to eligible centers of specialized treatment expertise when medically indicated; and providing for a fee schedule to be established by plans that have not entered into arrangements with provider. Balance billing is prohibited. States may not limit the ability of a plan to contract with any provider because the provider is located outside the State.

Sec. 1524. Health security cards

Each health plan shall issue a health security card to each enrolled individual.

Sec. 1525. Utilization management protocols and physician incentive plans

Establishes rules for utilization management protocols and limitations on physician incentive plans.

Part 2. Requirements related to essential community providers

Sec. 1531. Health plan requirement

(a) Health plans must, with respect to each electing essential community health provider (as defined in subsection (d)) located in the plan's service area, either

(1) Enter into a written provider participation agreement with the provider; or

(2) Enter into a written agreement under which the plan shall make payment to the provider in accordance with subsection (c).

(b) A participation agreement between a health plan and an essential community provider shall include terms and conditions at least as favorable as those applicable to other participating providers with respect to the following:

(1) The scope of services for which payment is made by the plan to the provider;

(2) The rate of payment for covered care and services;

(3) The availability of financial incentives;

(4) Limitations on financial risk provided to other providers;

(5) Assignment of enrollees to participating providers;

(6) Access by the provider's patients to the plan's specialists.

(c)(1) In the case of providers electing payment without regard to a participation agreement, the provider may elect to be paid either in accordance with the state fee schedule or on the basis of the most closely related Medicare payment rate or methodology, as specified by the Secretary of HHS in regulations. Payment may be subject to utilization review, but not to otherwise applicable gatekeeper requirements.

(2) In the case of FQHC's, the health plan is required to make payments based on the reasonable cost rates.

(d) As electing essential community provider is an essential community provider that is certified as an essential community provider under section 1681 and that elects to apply to the health plan. The Secretary of HHS shall specify the form and manner in which election is to occur; election shall include notice to the health plan. An election may be made once annually, unless the plan and provider agree to a more frequent election.

(e) In the case of essential providers that are school health clinics, each health plan shall pay to each school health provider an amount determined by the Secretary.

Sec. 1532. Recommendation on continuation of requirement

(a) The Secretary shall conduct studies of essential providers, how the term is defined, examining how payment is made, the effects of the contracting and payment requirements under this part, and other matters.

(b) No later than March 2001, the Secretary shall report to Congress with recommendations concerning the continuation, modifica-

tion or termination of the special health plan contracting requirements for essential providers.

SUBTITLE G. FEDERAL RESPONSIBILITIES

Part 1. National Health Board

Subpart A. Establishment of a National Health Board

Sec. 1601. Creation of a National Health Board; membership

A National Health Board, composed of nine members appointed by the President and subject to Senate confirmation, is created to oversee the implementation of Health Security Act. The Board shall have a chair designated by the President, who serves a term concurrent with that of the president and who shall also act as the chief executive officer of the Board. The Chair may serve a maximum of three terms; other members serve terms of 4 years. Rules on the staggering of terms and the filling of vacancies are also provided.

Sec. 1602. Qualifications of Board members

(a) Each member must be a United States citizen.

(b) Members will be selected on the basis of their experience and expertise in relevant subjects, such as the practice of medicine, nursing, or other clinical practices, health care financing and delivery, state health systems, consumer protection, business, law and delivery of care to vulnerable populations.

(c) Service on the Board shall constitute Federal employment and shall be exclusive employment.

(d) Members of the Board may hold no interest in an affected health care industry.

(e) Members are subject to post-employment restrictions applicable to comparable Federal employees.

(f) Federal pay schedules for the Board members and the Chair are specified at levels IV and II, respectively, of the Executive Schedule.

Sec. 1603. General duties and responsibilities

(a) The Board shall interpret the comprehensive benefit package, make adjustments in the delivery of preventive health services, and take such steps as may be necessary to assure that the comprehensive benefit package is available on a uniform national basis to all eligible individuals. The Board also may recommend to the President and Congress changes in the benefit package that are appropriate in light of changes in technology, health care needs, health care costs, and methods of service delivery.

The Board shall recommend changes, including changes in the benefit package, to the Congress if previously unprojected increases in the Federal deficit will result from the operations of the act. Recommended changes to the benefit package must be considered under a base closing procedure.

(b) The Board shall oversee the cost containment provisions of title VI.

(c) The Board shall develop rules for eligibility, plan coverage of certain individuals, and treatment of families.

(d) The Board shall oversee the performance based quality management system described in title V.

(e) The Board shall oversee the development of the national health information system described in title V.

(f) The Board shall establish standards for participating States, monitor State compliance and provide technical assistance in a manner that assures access to the comprehensive benefit package.

(g) The Board shall develop premium class factors under subpart D.

(h) The Board shall develop a risk adjustment methodology for premium payments to plans in accordance with subpart E.

(i) The Board shall establish minimum capital requirements and requirements for guaranty funds under subpart F.

(j) The Board shall establish standards for health plan grievance procedures.

(k) The Board shall specify a national open enrollment period.

(l) The Board shall, in consultation with the Secretary of Labor, establish fiduciary requirements for the management of funds by States, plans, cooperatives, and employers.

Sec. 1604. Annual report.

(a) The Board shall prepare and send to Congress and the President an annual report addressing overall implementation of the system. The report shall include information on Federal and State implementation, quality data, recommendations or changes in the administration, regulation, and laws related to health care coverage, and a full account of Board actions in the preceding year.

Sec. 1605. Powers.

(a) The Board shall have authority, consistent with Federal civil service laws, to appoint officers and employees and may enter into contracts for studies and analyses. Executive branch employees may be detailed to assist the Board in carrying out its duties.

(b) The Board may establish advisory committees.

(c) The Board may secure directly (from any Federal agency) necessary information to the extent such information is available to a Federal department or agency.

(d) The Board may delegate functions to officers and employees but may not be relieved of responsibility for administration of such functions.

(e) The Board may promulgate rules needed to carry out the act.

Sec. 1606. Funding

(a) There are authorized such sums as may be necessary for fiscal years 1994 through fiscal years 1998. The Office of Management and Budget shall review the Boards's budget annually.

Subpart B—Responsibilities relating to review and approval of State systems

Sec. 1611. Federal review and action on State systems.

(a)(1) The Board shall approve a state health care system unless the board finds that the system does not or will not provide for the State to meet its participation responsibilities under the Act.

(2) The Board shall issue regulations outlining participation requirements by July 1, 1995. The Board must take action on States intending to participate before the date of issuance of regulation.

(3) The Board may not approve a State health care system for any year prior to 1996.

(b)(1) The Board must notify states within 7 days of the receipt of documents as to whether the document is complete and provides the Board with sufficient information to approve or disapprove the State's plan.

(2) In the case of incomplete documents, States have 45 days to submit additional information.

(c) The Board shall act on a State proposal within 90 days after the State has submitted a complete document. The Board's failure to act within the prescribed time period shall be deemed to be approval of the State's document.

(d) If the Board does not approve a State's document, the State has 30 days in which to submit additional information. The Board shall respond to this additional information within 30 days. If the Board does not meet this deadline, the plan is deemed approved.

(e) If the Board terminates its approval of a State's system, it shall approve the system in a succeeding year if the State satisfies the Board that the cause of its failure no longer exists and provides reasonable assurances that the actions that formed the basis of the termination will not recur.

(f) A State may revise its system, but revisions will not take effect until the Board has approved documents revising the State system. The Board shall act on State amendments within 60 days of submission. If the Board fails to act within 60 days, the revision shall be considered approved. A State shall have an opportunity to respond to rejected revisions.

(g) If a State fails to submit documents to become a participating State, the Board shall notify the Secretary of HHS and the Secretary of the Treasury.

Sec. 1612. Failure of participating States to meet conditions for compliance

(a) If the Board determines that a State system fails to meet the requirements of the act, sanctions shall be imposed in accordance with subsection (b).

(b)(1) If the Board determines that the State's failure does not substantially jeopardize individuals' access to health coverage, it may directly order compliance by a regional alliance to correct the problem and may, if it determines that the problem has not been corrected, notify the Secretary of Health and Human Services who shall reduce payments in accordance with section 1513.

(2) If the Board determines that the State's noncompliance substantially jeopardizes individuals' access to coverage, it shall terminate its approval of the State's plan and notify the Secretary, who shall assume the duties described in section 1522.

(c) A State against which a sanction has been imposed may submit information at any time to demonstrate that the failure has been corrected. Following a determination the Board may then notify the alliance that has been sanctioned or notify the Secretary

in the case of other sanctions that have been applied against the state under subsection (b).

(d) The Secretary shall exercise authority only in a manner that assures uninterrupted coverage for individuals in the State.

Sec. 1613. Reduction in payments for health programs by the Secretary of Health and Human Services

(a) Upon receiving notice from the Board, the Secretary shall reduce certain payments that otherwise would be made to individuals and entities in the State.

(b) Payments subject to reduction are:

- (1) Payments to academic health centers under title III;
- (2) Payments for health services research funded under the Public Health Service Act;
- (3) Payments to hospitals serving vulnerable populations under title III.

Sec. 1614. Review of Federal determination

A State or alliance that is affected by a decision of the Board may appeal the decision under section 5231 of the Act.

Sec. 1615. Federal support for State implementation

(a) Not later than 90 days after enactment, the Secretary shall make planning grants available to each state to develop the system needed to become a participating State. Funds for this purpose will be distributed according to a formula developed by the Secretary. Appropriations of \$50,000,000 in each of fiscal years 1995 and 1996 are authorized.

(b) States that have enacted enabling legislation qualify for grants to assist in the development of regional alliances. Grants shall be allocated in accordance with a formula developed by the Secretary. States must expend amounts equal to the amount made available under this section in order to qualify for Federal assistance. Authorized funding levels are \$313,000,000 for fiscal year 1996, \$625,000,000 for fiscal year 1997, and \$131,000,000 for fiscal year 1998.

Subpart C. Responsibilities in the absence of a State system

Sec. 1621. Application of subpart

(a) This section applies to states beginning January 1, 1998, unless the state submits its documents by July 1, 1997, and the Board determines that the State meets the requirements of the Act.

(b) In the case of States whose systems have been disapproved, this subpart becomes effective as of a date that is appropriate to assure that continuity of coverage for the comprehensive benefit for eligible individuals is not lost.

Sec. 1622. Federal assumption of responsibilities in non-participating States

(a) When the Board determines that this subpart applies to a State in a calendar year, it shall notify the Secretary.

(b) Upon receiving notice the Secretary shall take such steps as are necessary to ensure the provision of the comprehensive benefit package to individuals in the State.

(c) The Secretary shall establish a guaranty fund to provide financial protection for health care providers and individuals in the event of an health plan failure under a health care system established and operated by the Secretary. The Secretary is authorized to impose assessments on health plans for so long as necessary to generate sufficient revenues for the guaranty fund.

Sec. 1623. Imposition of surcharge on premiums under federally operated systems

(a) In operating a system under this subpart, the Secretary shall impose premiums equal to the amount that otherwise would have imposed, increased by an additional 15 percent to reimburse the Secretary for express incurred in operating the system.

(b) The 15 percent surcharge shall be treated as part of the premium.

Sec. 1624. Return to State alliance

(a) A State may apply at any time for approval to assume operation of a federally administered alliance system.

(b) If the Board approves the State's application, the state's take-over shall begin as of January 1, following the date of approval.

Subpart D. Establishment of class factors for charging premiums

Sec. 1631. Premium class factors

(a) For each class of family enrollment under Section 1011(c), the Board shall establish a premium class factor that reflects the relative actuarial value of the comprehensive benefit package of the class of family enrollment, compared to individual enrollment. The factor for individual enrollment shall be one, and the factor for a couple-only class shall be two.

Subpart E. Risk adjustment and reinsurance methodology for payment of plans

Sec. 1641. Development of a risk adjustment and reinsurance methodology

(a) By April 1995, the Board shall develop a risk adjustment and reinsurance methodology. The Board shall make improvements in the methodology as appropriate in order to achieve the purposes of the methodology.

(b)(1) The purposes of the methodology are to assure that payments to plans reflect expected utilization and expenditures for such services by plan enrollees compared to average utilization and expenditure rates and to protect plans that enroll a disproportionate share of individuals whose utilization and expenditures are higher than average.

(2) In developing its methodology, the Board shall consider the following factors:

- (A) Demographic characteristics;
- (B) Health status;
- (C) Geographic area of residence;

(D) Socio-economic status;

(E) The proportion of enrollees who are SSI and AFDC recipients unless the Board concludes that other risk adjustment factors are sufficient to adjust premiums to take into account the effects of high AFDC and SSI enrollment;

(F) Other material factors identified by the Board.

(3) The methodology shall assure that the total payment to health plans in the alliance would be the same after application of the factors as in the absence of the risk adjusters.

(4) The Board may eliminate a special AFDC and SSI adjustment if it determines that other adjustments are sufficient.

(5) The Board shall give special consideration to payment adjustments with respect to persons with mental illness.

(6) The Board shall give special consideration to adjustment for Indian, Veterans and Department of Defense health plans.

(7) If total payments by a regional alliance to its health plans either exceed or fall short of the total of such payments estimated by the alliance using the Board's risk adjustment methodology, and if the problem results from a discrepancy between the alliance estimate of the distribution of enrolled families by risk categories and their actual distribution, the Board shall adjust its methodology in a succeeding year by the amount of the excess or deficit to take the discrepancy into account.

(c) The Board's methodology shall include a system of mandatory reinsurance, but not voluntary reinsurance, which shall be eliminated at such time as the Board determines an adequate risk adjustment program has been established

(d) The Board shall assure that reinsurance systems are developed in conformity with confidentiality requirements.

(e) The Board may experiment with different methods in different states.

(f) States may, with the approval of the Board, add State-specific components to the methodology.

Sec. 1642. Incentives to enroll disadvantaged groups

The Board shall establish standards to permit States to adjust the risk adjustment methodology to create financial incentives for health plans to enroll disadvantaged groups.

Sec. 1643. Research and demonstrations

The Secretary shall conduct research and demonstrations to aid in the development of a risk adjustment methodology.

Sec. 1644. Technical assistance to States and alliances

The Board shall assist States and alliances to implement the risk adjustment methodology.

Subpart F. Responsibilities for financial requirements

Sec. 1651. Capital standards for regional alliance health plans

(a) The Board shall develop in consultation with the States, minimum capital requirements for carriers.

(b) There must be at least \$500,000 in capital maintained.

(c) The Board may require additional capital, based on factors likely to affect the financial stability of health plans, including the following factors:

(1) Projected plan enrollment and the number of participating providers;

(2) Market share and strength of competition;

(3) Extent and nature of risk sharing with participating providers and their financial stability;

(4) Prior performance of the plan, its risk history, and liquidity of assets.

(d) Special standards may be established for community and provider-based plans.

(e) The National Association of Insurance Commissioners shall develop model standards for additional capital requirements for the Board by July 1, 1995. The Board may accept or modify such standards.

Sec. 1652. Standards for guaranty funds

(a) In consultation with the States, the Board shall develop standards for State guaranty funds.

(b) Standards shall include the following:

(1) A fund must be able to generate sufficient resources to pay providers and others in the event of plan failure, in order to meet obligations with respect to services rendered by providers for the comprehensive benefit package and any supplemental coverage for cost sharing. Fund resources must also be sufficient to meet plan obligations for services rendered prior to and after plan insolvency, before they plan to enroll in other health plans.

(2) The fund must be liable for all claims against the plan by health care providers with respect to items and services furnished under the comprehensive benefit package.

(3) The fund stands as a creditor for payments owed the plan, to the extent of payments made by the fund for plan obligations.

(4) The fund has authority to borrow against future assessments.

Subpart G. Open enrollment

Sec. 1660. Periods of authorized changes in enrollment

The Board shall establish a national open enrollment period, shall establish other permissible methods for changing enrollment and for disenrollment for cause, shall provide for direct enrollment with health plans, shall provide standards to assure the broad availability of enrollment forms, including direct enrollment through the mail. Marketing fees are prohibited in certain circumstances. The Board shall establish standards for provider-based enrollment mechanisms and coordination of enrollment activities among States.

Sec. 1661. Distribution of comparative information

The Board shall specify a period prior to open enrollment during which State must distribute to community-rate eligible individuals enrollment materials and comparative information on health plans.

Part 2. Responsibilities of the Department of Health and Human Services

Subpart A. General responsibilities

Sec. 1671. General responsibilities of the Secretary of Health and Human Services

(a) Except as specifically provided, the Secretary shall administer all provisions of the act except those delegated to the National Board, any other executive agency or a State.

(b) The Secretary shall develop financial management standards.

(c) The Secretary shall periodically audit the performance of States in carrying out responsibilities under the act.

Sec. 1672. Medical technology impact study

Establishes a medical technology impact study to be carried out by the administrator of the agency for Health Care Policy and Research.

Sec. 1673. Assistance with family collections

The Secretary shall provide States with technical and other assistance, including the imposition of civil money penalties, to promote the efficient collection of premiums owed by families.

Sec. 1674. Advisory opinions

Community and provider-based plans may seek advisory opinions as to their compliance with certain Federal laws.

Sec. 1675. Reports

The Secretary shall undertake studies of coverage of certain dental care and oral health benefits and of in vitro fertilization.

Subpart B. Certification of essential community providers

Sec. 1681. Certification

(a) The Secretary shall certify as an "essential community provider" any health care provider or organization that:

(1) Is within any of the categories specified in section 1682(a)

or

(2) Meets certification standards under section 1683(a).

(b) The Secretary shall develop a certification process that permits providers to be certified prior to the date of implementation of the act in a State.

Sec. 1682. Categories of providers automatically certified

(a) The following providers are automatically certified as essential community providers:

(1) Covered entities under Section 340B(a)(4) of the Public Health Service Act (i.e. providers eligible for discount prescription drugs);

(2) Providers of school health services receiving funding under title III;

(3) Nonprofit hospitals serving large numbers of low-income individuals;

(4) Medicare dependent small rural hospitals;

(5) Children's hospitals serving large numbers of poor children;

(6) Public and private nonprofit mental health and substance abuse treatment providers;

(7) Providers of health services to homeless and runaway youth;

(8) Public and private nonprofit entities furnishing prenatal, pediatric or ambulatory services to children, including children with special health care needs and that receive funding under Title V of the Social Security Act; and

(9) Rural health clinics.

(b) **STUDY OF FEDERALLY CERTIFIED RURAL HEALTH CLINICS.**—The Secretary shall conduct a study of rural health clinics to examine the causes of growth in the program and the characteristics of the population served by these clinics.

Sec. 1683. Standards for additional providers

(a) The Secretary shall publish standards for certification of additional categories of health care providers and organizations as essential community providers. Such health providers may be certified only if the Secretary determines that health plans operating in areas served by the applicant would not be able to assure adequate access to the comprehensive benefit package without contracting with the applicant.

(b) Optional categories include:

(1) Health professionals (including physicians, nurses, nurse practitioners, certified nurse midwives, physicians assistants, psychologists, dentists, pharmacists, clinical social workers, chiropractors, and other health care professionals recognized by the Secretary) who meet various criteria, including that they be located in a health professions shortage area (as the term is used in Section 332 of the Public Health Services Act), or who provide a substantial amount of health services to medically underserved populations (as the term is used in Section 330 of the Public Health Service Act).

(2) Institutional providers meeting similar location and service requirements as health professionals.

(3) Other public and private nonprofit agencies and organizations that meet similar location or service requirements for health professionals.

Sec. 1684. Certification process; review; termination of certifications

(a)(1) The Secretary shall decide on public certification procedures within 6 months of enactment of this act and shall describe the form and manner in which application for certification is to be made.

(2) The Secretary shall act on an application under section 1682 within 15 days and on an application under section 1683 within 60

days of submission of a completed application. Certification of entities under section 1682 shall only involve verifying that the entity falls into one of the automatic certification classes.

(b) The Secretary shall periodically review certified essential community providers to determine that they meet the requirements of this subpart.

(c) If the Secretary finds that an entity does not meet certification requirements or fails to continue to meet such requirements, the Secretary shall notify the entity and permit the entity an opportunity to rebut such findings. If the Secretary continues to find that the entity fails to meet the requirements of this subpart, the Secretary shall notify the entity and regional and corporate alliances of the termination and its effective date.

Sec. 1685. Notification of health alliances and participation States

(a) The Secretary shall notify participating States and health alliances regarding certified essential providers. The notice shall include sufficient information to permit each health alliance to identify the provider; the notice must also report to health plans the location of the provider, the health services furnished by the provider and other information necessary for health plans to carry out their duties under subtitle E of title I.

Sec. 1686. Definitions and study

(b) Requires the Secretary to study various aspects of providers designated as rural health clinics and report to the Congress.

Sec. 1686. Establishes definitions related to this subpart

Subpart C. Workplace wellness programs

Sec. 1687. Workplace wellness programs

Secretary shall establish criteria for worksite wellness programs. Employers maintaining qualified programs are entitled to a rebate. Elements for qualified programs that the Secretary shall consider in establishing criteria are listed.

Sec. 1688. Wellness discount methodology

The Secretary shall establish a methodology ensure that families and employers entitled to appropriate wellness discounts receive them.

Part 3. Specific duties of the Secretary of Labor

Sec. 1691. Responsibilities of the Secretary of Labor

(a) The Secretary is responsible for enforcement of requirements on employers under subtitle D, temporary administration of insolvent plans of large group purchasers, carrying out other responsibilities assigned to the Secretary under the act, and for administering Title I of ERISA as it relates to large group purchasers.

(b) The Secretary of Labor may enter into agreements with States to enforce responsibilities of employers and large group purchasers under subtitle B of Title I of ERISA.

(c) In carrying out his or her responsibilities, the Secretary shall consult with the Board.

(d) The Secretary shall conduct a study of the impact of employer requirements to make contributions on behalf of seasonal workers.

(e)(1) The Secretary of Labor shall assure that employers pay premiums and withhold and make payment for the family share of premiums, submit timely reports, and otherwise comply with the requirements of the act.

(2) The Secretary of Labor may carry out audits and similar authorities.

(3) Each State is responsible for auditing the records of community-rated employers to assure employer payments were made in the appropriate amount.

(f) The Secretary of Labor is authorized to issue such regulations as are necessary to carry out the responsibilities of the Secretary under the act.

Sec. 1692. Assistance with employer collections

The Secretary of Labor shall provide States with such technical assistance as may promote the efficient collection of amounts owed under this act by employers, including assessment of civil monetary penalties.

Sec. 1693. Penalties for failure of large employers to meet requirements

Establishes penalties for failure to meet requirements and provides for contracts with community-rated plans in the event of failure to meet cost-containment targets.

Sec. 1694. Applicability of ERISA enforcement mechanisms for enforcement for certain requirements

Specifies that ERISA enforcement mechanisms apply to applicable requirements for large group purchasers.

Part 4. Collective bargaining dispute resolution

Sec. 1695. Findings and purposes

Provides that, consistent with the intention of the Health Security act to eliminate waste and inefficiency in the health care industry and the importance of avoiding costly and disruptive labor disputes that may otherwise arise during the period of transition to a restructured health care delivery system because of disruptions to established employment relations, it is the purpose of this part to expand the ability of the Federal Mediation and Conciliation Service to avoid labor disputes by providing for public fact finding in contract negotiations.

Sec. 1696. Application limited to transition period

Provides that the provisions of this part are intended to apply only during the period of transition to a restructured health care delivery system and shall be repealed at the end of the year 2000.

Sec. 1697. Request for appointment of board of inquiry

Authorizes either party to a collective bargaining dispute a health care entity and a labor organization representing employees of the health care entity to request the Director of the Federal Mediation and Conciliation Service to appoint an Impartial Board of Inquiry to investigate the issues involved in the dispute, and provides that the request may be made no earlier than 60 days after notice of the dispute has been provided to appropriate Federal or State agencies in accordance with applicable law.

Sec. 1698. Appointment of board of inquiry

Provides that the Director of the Federal Mediation and Conciliation Service shall appoint a Board of Inquiry no later than 10 days after receipt of a request, unless comparable procedures for resolution of the impasse are available under applicable State law or have been agreed to by the parties. Provides that no member of the Board may have any interest or involvement in either party to the dispute.

Sec. 1699. Public factfinding

Requires a Board of Inquiry appointed under this part to investigate the issues involved in the dispute, make a written report to the Director within 30 days containing its finding of fact together with recommendations for settling the dispute, and arrange for publication of the report within the community served by the health care entity involved.

Sec. 1699A. Compensation of members of boards of inquiry

Specifies the rate of compensation for members of Board of Inquiry.

Sec. 1699B. Maintenance of status quo

Provides that after establishment of a Board of Inquiry, and for 15 days after the Board has issued its report, neither party may make any change in the status quo as it existed prior to the expiration of the contract (in the case of negotiations for a contract renewal) or prior to the time the parties began their bargaining (in the case of negotiations for a first contract between the parties), except by mutual agreement.

SUBTITLE H. MISCELLANEOUS EMPLOYER REQUIREMENTS

Sec. 1701. Auditing of records

Requires employers to maintain appropriate records.

Sec. 1702. Prohibition of certain employer discrimination

Prohibits employers from discriminating against current or prospective employees on the basis of class of family enrollment.

Sec. 1703. Evasion of obligations

Prohibits action against employees designed to prevent employees from achieving eligibility for coverage.

Sec. 1704. Prohibition on self-funding of cost sharing benefits

Prohibits self-funding of cost-sharing policies by community-rated employers.

Sec. 1705. Employee retiree obligation

Defines employer contribution requirements for health plans for early retirees.

Sec. 1706. Rules governing litigation involving retiree health benefits

Requires maintenance of retiree health benefits while litigation is pending.

Sec. 1707. Participation in OPM insurance program

Provides for participation of American employees of American employers abroad in an insurance program maintained by the Office of Personnel Management.

Sec. 1708. Certain contracts with fee for service plans

A contract under section 1404 with a fee-for-service plan will reimburse all providers for items and service included in the comprehensive benefits package, regardless of where such services are delivered, for an employee who is a citizen or resident of the United States and who is performing service outside the country for an experienced-rated employer.

Sec. 1709. Enforcement

Provides for civil money penalties for violation of the provisions of this Section.

SUBTITLE I. DEFINITIONS; MISCELLANEOUS PROVISIONS

Part 1. General definitions

Sections 1901 and 1902 provide general definitions for a number of terms included in the act. Section 1903 describes terms that are deemed to be a reference to another term.

Sec. 1903. References to certain items

In any provision of this act—

(1) any reference to a corporate alliance employer is deemed a reference to an “experience-rated employer”;

(2) any reference to a “corporate alliance” is deemed a reference to a “large group purchaser”;

(3) any reference to a “corporate alliance eligible individual” is deemed a reference to an “experienced-rated individual”

Other terms are deemed to conform to appropriate definitions in the committee bill.

*Part 2. Miscellaneous provisions**Sec. 1911. Use of interim final regulations*

To assure timely promulgation of rules, the Board, the Secretary of HHS, and the Secretary of Labor are authorized to promulgate

rules on an interim final basis that become final on the date of publication and are subject to subsequent public comment.

Sec. 1912. Neutrality concerning union organizing

Amounts appropriated under the act may not be used to assist, promote, or deter union organizing.

Sec. 1913. Social Security Act references

Except as provided, references to the Social Security Act are references to the act as in effect on the date of enactment.

Sec. 1914. Antidiscrimination

Prohibits discrimination by entities subject to the act.

Sec. 1915. Coverage of benefits under Health Security Act

Makes technical changes to Section 1(b)(2) of the Davis-Bacon Act and to Section 2(a)(2) of the Service Contract Act of 1965 to take into account benefits provided pursuant to the Health Security Act in making wage determinations under such acts.

Sec. 1916. Government required data

The set of data referred to in section 5114(a)(5) shall include data on:

- (1) Enrollment and disenrollment from plans;
- (2) Clinical encounters and other data from providers;
- (3) Administrative, operational and financial aspects; regarding the composition, transactions and activities of various parties that are necessary to determine compliance with this act;
- (4) Terms of agreement between health plans and providers who are members of the plans
- (5) Payment of benefits in certain cases
- (6) Utilization management by plans and providers
- (7) Information collected and reported to the Board of disseminated to other individuals under subtitle A of title V
- (8) Grievances and the resolution of such grievances
- (9) Any other fact that may be necessary to determine whether a plan or provider has complied with a Federal statute pertaining to fraud or misrepresentation.

Sec. 1917. Sense of the committee concerning funding sources

(a) It is the sense of the Committee on Labor and Human Resources of the Senate that when the Health Security Act is enacted it should include the following sources of financing not within the jurisdiction of the committee.

- (1) The net savings and revenues included in S. 1757
- (2) The extension to all employer who are not community-rated the 1 percent payroll assessment applied to corporate alliances in the Health Security Act.
- (3) An increase in the cigarette tax of \$.75 per pack in excess of the amount specified in S. 1757.
- (4) A phased-in 1 percent premium assessment equal to the additional amount provided for biomedical research under title III of this act.

(b) It is the sense of the committee that when health reform is enacted, it should include a permanent extension of the research and development tax credit.

Sec. 1918

It is the sense of the committee that provisions encouraging medical savings accounts be included in any reform bill passed by the Senate, in conjunction with health benefit plans covering the comprehensive benefits package described in subtitle b of title I.

Title II

Part 1. State programs for home and community-based services for individuals with disabilities

Subpart A. Home and community-based services

Sec. 2101. State programs for home and community-based services for individuals with disabilities

Subsection (a) states that each State that has an approved plan for home and community-based services to individuals with disabilities is entitled to payment in accordance with section 2108.

Subsection (b) clarifies that there is no individual entitlement to services or a requirement that a State with an approved plan expend the entire amount of funds to which it is entitled.

Subsection (c) gives the Secretary 6 months in which to designate an administrative agency.

Sec. 2102. State plans

Subsection (a) sets forth the following plan requirements. A process for the initial screening of individuals must be conducted by a public or private, nonprofit agency that does not provide or have an interest in an entity that provides long-term care services. There are exceptions to this conflict of interest provision for providers of residential care and in areas of the State in which there is an insufficiency of available service providers.

The plan may not limit eligibility based on: income; age; geography; nature, severity, or category of disability; residential setting (other than an institutional setting); or other grounds specified by the Secretary. There are certain exceptions to these provisions during the program's phase-in.

Individuals who are receiving Medicaid home and community-based services must continue to receive an appropriate level of assistance.

By the end of the second year of implementation, there must be a statewide assessment of needs conducted according to the Secretary's specifications.

The plan must specify the services made available, the extent and manner in which services are allocated, and the manner in which services are coordinated with other long-term care services.

A State plan may take into account the availability of informal care, in determining the amount and array of services made available to covered individuals.

The State plan must specify how it will: allocate services; meet the needs of all categories of individuals with disabilities; dem-

onstrate that services are allocated equitably; and ensure the proportion of low-income individuals who are served, in this program and under Medicaid, is at least in proportion to their population in the State.

The State may not subject consumer-directed providers of personal assistance services to licensure, certification, or other unnecessary requirements. The choices of consumers regarding services and providers shall be followed, to the extent feasible.

Cost-sharing may be imposed only in accordance with section 2105.

The plan must specify the types of service providers that are eligible to participate (which must include consumer-directed providers) and any requirements for participation applicable to each type of provider.

The plan must specify how the State will manage program funds, which methods will be used to reimburse providers, and the methods and criteria used to set payment rates. Balance billing is prohibited; all providers must accept plan payments and cost-sharing as payment in full.

The plan must adhere to the quality assurance provisions of section 2106, and must establish an advisory group as described in section 2107.

An administering agency must be designated. There also must be a single point of access to information for consumers. The plan must specify how it will integrate and coordinate with other long-term care and health services.

Administrative expenditures may not exceed 10 percent, except during the program's phase-in, during which expenditures for claims processing, information retrieval, and infrastructure development may comprise up to an additional 10 percent of expenditures.

The State must provide reports as required by the Secretary, in the format specified.

Subsection (b) describes the criteria for approval of State plans, which include a public comment period of not less than 30 days, and meeting all the criteria of subsection (a).

Subsection (c) indicates that the Secretary will monitor plan compliance annually, and may withhold funds for failure to comply.

Subsection (d) ensures the availability of ongoing technical assistance to the States.

Subsection (e) states that the Secretary shall issue appropriate regulations on a timely basis.

Sec. 2103. Individuals with disabilities defined

Subsection (a) describes for the four categories of eligible individuals. Eligible individuals must meet one of the following criteria (and, in categories 1, 2, and 4, be expected to require assistance for at least 90 days):

1. Require hands-on or standby assistance, supervision, or cueing to perform three or more activities of daily living.

2. Have a score on a stand mental states protocol designed to measure severe cognitive or mental impairment and

Require hands-on or standby assistance, supervision, or cueing with one or more activity of daily living;

Require hands-on or standby assistance, supervision, or cueing with at least such instrumental activity of daily living related to cognitive or mental impairment as the Secretary specifies; or

Display a behavioral problem that creates a need for supervision to prevent harm to self or others.

3. Have severe or profound mental retardation.

4. Be an individual under age 6 who has a severe disability or chronic medical condition that limits functioning in a manner that is comparable in severity to the criteria listed above.

Subsection (b) describes the criteria for making eligibility determinations, using a uniform protocol. Cost-sharing may not be imposed for the eligibility determination. The State must establish a fair hearing process for appeals of eligibility determinations.

States may expend not more than 2 percent of their funds to serve individuals with disabilities of comparable severity who fail to meet the eligibility criteria of any single category.

Eligibility must be periodically reassessed.

Activities of daily living are defined as eating, toiling, dressing, bathing, and transferring.

Sec. 2104. Home and community-based services covered under the state plan

Subsection (a) requires the State plan to specify the services that will be made available to individuals with disabilities and any limits on such services. This subsection also clarifies that services may be delivered in the individual's home, a range of community residential arrangements, or outside the individual's home.

Subsection (b) describes the requirements for care management. No individual may receive services unless he or she has received a comprehensive needs assessment, an individualized plan of care, and services are delivered consistent with such care plan. In addition to these requirements, the State must make available arrangements for the provision of services, and monitoring of the delivery of services.

States must use a uniform comprehensive assessment tool developed by the Secretary and may use alternative assessment tools only with the Secretary's approval. The Secretary will provide guidance to the States with regard to the appropriate qualifications for individuals who conduct assessments.

This subsection also specifies that the individualized care plan must be developed by qualified individuals, in consultation with the individual, approved by the individual, and reviewed and updated not less than every 6 months. The care plan must specify which services will be provided, identify how the individual will be provided any services specified under the plan but not provided under the State plan, and specify how services will be coordinated with other health services.

Subsection (c) requires the State plan to make available both agency-administered and consumer-directed personal assistance services.

Subsection (d) allows the States to provide any of the following services: homemaker and chore assistance; home modifications; respite services; assistive devices; adult day services; habilitation and

rehabilitation; supported employment; home health services; and transportation. Other services may be provided with the Secretary's approval.

The State plan must specify how it selects which services to provide and must demonstrate how such services will provide substantial assistance in living independently. By the time the plan is fully phased-in it is expected that the State will make available a full array of services.

Subsection (e) prohibits a State plan from providing coverage of room and board, services in an institution, or items covered by Medicare or under a health plan.

Subsection (f) allows a State to use vouchers, cash payments, capitated payments to health plans, or payments to providers to pay for covered services.

Subsection (g) defines personal assistance services. It also defines consumer-directed services as those that are provided by an individual who is selected and managed by the individual receiving services. When a beneficiary is a consumer-directed recipient of services, the State must: inform both recipients and providers of services as to their responsibilities under all applicable Federal labor and tax law; assume responsibility for providing effective billing, payments for services, tax withholding, unemployment insurance, and workers' compensation; and act as the employer of the home care provider. However, the consumer retains the right to independently select, hire, terminate, and direct the home care worker.

Agency-administered services are those that are not consumer-directed.

Sec. 2105. Cost sharing

Cost sharing is imposed according to the following schedule:

Income (percent of poverty):	Percent
<150	0
150-199	10
200-249	20
250+	25

The Secretary is required to establish a method for reducing cost-sharing for individuals with extraordinarily high out-of-pocket expenses for whom such cost-sharing would jeopardize their ability to take advantage of the services offered under this act.

In determining income for the purposes of cost-sharing, States must adhere to uniform Federal definitions of income and allowable deductions from income.

Sec. 2106. Quality assurance safeguards

Subsection (a) establishes minimum requirements for providers, including: safeguarding the health and safety of individuals with disabilities; establishing minimum standards for agency providers; establishing minimum competency requirements; obtaining meaningful consumer input; participating in quality assurance activities; and clarifying the role of the existing State consumer protection and advocacy resources.

The Secretary must promulgate regulations regarding confidentiality and safeguards against abuse, and may not delegate such

authority to the States. However, States may impose more stringent quality assurance standards.

Subsection (b) also establishes Federal standards for: case reviews; random home visits; reporting of abuse; establishment of client grievance procedures; licensure for home health services; training requirements for agency-administered home care workers; development of a registry of provider agencies against whom complaints have been sustained; sanctions to be imposed for failure to meet standards; surveys of client satisfaction; and optional training programs for informal caregivers.

Subsection (c) establishes funding for client advocacy activities.

Subsection (d) describes the functions of the client advocacy office, which include: identifying, investigating, and resolving complaints; providing services to assist clients; informing clients about how to obtain services; ensuring that clients have access to services; and representing the interests of clients.

Subsection (e) provides for safeguards with regard to confidentiality and abuse.

Sec. 2107. Advisory groups

Federal and State-level advisory groups must be established and must include individuals with disabilities and their representatives.

Sec. 2108. Payments to States

This Section establishes payment amounts to States with approved plans. Payments for home and community-based services delivered are equal to the Federal matching percent; quality assurance activities, eligibility determinations, claims processing, and infrastructure development are reimbursed at 90 percent. Remaining administrative expenses are reimbursed at 50 percent. One-half of one percent of the State's allotment is paid exclusively for client advocacy activities.

The Federal matching percentage is 17.5 points higher than the State's Medicaid matching percentage, except that it shall be no less than 67.5 percent and no more than 95 percent.

Sec. 2109. Appropriation; allotment to States

Funding for the program is established as follows: fiscal year 1996—\$3.9 billion; fiscal year 1997—\$6.8 billion; fiscal year 1998—\$9.6 billion; fiscal year 1999—\$12.9 billion; fiscal year 2000—\$16.4 billion; fiscal year 2001—\$23.4 billion; fiscal year 2002—\$31.1 billion; and fiscal year 2003—\$33.6 billion. In subsequent years, funds will be increased based on changes in the CPI and the number of individuals with disabilities. The Federal Government is obligated to provide for these payments to States.

Participating States must inform the Secretary as to offsets and reductions in the Medicaid program as a result of expenditures under this program. Reductions in Federal Medicaid expenditures as a result of this program shall be used to increase the total Federal budget available to States.

Federal allotments to States are based on a formula that includes the number of individuals with disabilities in the State, av-

erage wages in the State, the percentage of the State's population that is low-income, and the Federal matching percentage.

During the phase-in, a State may carry-over up to 25 percent of its allotment for expenditure in the subsequent year.

Sec. 2110. Federal evaluations

This Section requires the Secretary to provide analytical reports to Congress.

Subpart B

Sec. 2111. State programs for extended services for children with special health care needs

Provides for grants to States for programs to establish a supplemental long-term care program of extended services for children with special health care needs.

Sec. 2112. Extended services covered under the State plan

Establishes basic criteria for assessing patient's need for services and the development of a care plan. Establishes a package of mandatory services covered under the plan available to all children with disabilities eligible for plan. Formulates the criteria for selection of services by the State and identifies options for payment for services.

Sec. 2113. Children eligible for services

Identifies eligible individuals for services based on lack of eligibility for medical services under Medicaid (title IV), significant age-specific functional impairment, and clear need of child for extended services to maximize or restore function, or prevent or limit disability.

Sec. 2114. Application and administration

Establishes the application process for States based on identification of disability community and needs for services. Makes grants available for the maximum number of State programs. Designates a State lead agency to coordinate services and providers.

Sec. 2115. Cost-sharing

Establishes cost-sharing methods for families based on annual income level and utilization of services. Allows for the Secretary to further develop other cost-sharing methods and allows families to request from state a pro-payment system.

Sec. 2116. Program evaluation

Requires States to complete an interim program evaluation on issues of interest to the Congress.

Sec. 2117. Total Federal budget and Federal allotment to States provides Federal funds equal to a 2-percent set-aside from the long-term care proposal subpart A

Requires at amount specified in subpart A. Funds remaining at the end of the fiscal year will be made available to the State for the following fiscal year.

Part 2. Long-term care insurance improvement and accountability

Sec. 2201. Short title

This part may be cited as the "Long-Term Care Insurance Improvement and Accountability Act."

Sec. 2202. Establishment of Federal standards for long-term care insurance

This part amends the Public Health Service Act.

Subpart A. Promulgation of standards and model benefits

Sec 2701. Standards

Subsection (a) states that if within 12 months of the date of the enactment of this title, the National Association of Insurance Commissioners (NAIC) promulgates model standards that incorporate the requirements of this title, the Secretary shall have 60 days in which to determine whether such standards implement the requirements of this part. If approved by the Secretary, such standards shall apply as provided in this title. If the NAIC does not promulgate model standards by the deadline, the Secretary shall provide, within 12 months of that deadline, standards that incorporate the requirements of this title and such standards shall apply. However, nothing in this title prevents States from applying standards that provide greater protection to policy holders than the standards set by this title, except that such State standards may not be inconsistent with the requirements of this title.

Subsection (b) states that the application deadline of these standards is the date the State adopts the standards, or 1 year after the first day of the first legislative session that begins after the date such standard are first established—whichever is earlier. In States identified by the Secretary, in consultation with the NAIC, as requiring legislation other than legislation appropriating funds in order to establish standards, but having a legislature which is not scheduled to meet within 1 year following the beginning of the next regular legislative session in which such legislation may be considered, the date specified in this subsection is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1995. In the case of a State that has a 2-year legislative session, each year of the session shall be deemed as a separate regular session of the State legislature.

Subsection (c) identifies items to be included in the standards promulgated under subsection (a). These standards are: minimum Federal standards for long-term care insurance consistent with the provisions of this title; standards for the enhanced protection of consumers with long-term care insurance; procedures to modify the established standard to expand existing Federal or State long-term care benefits or establish a comprehensive Federal or State long-term care benefit program; and other activities determined appropriate by Congress.

Subsection (d) establishes a process for the Secretary to consult with representatives of carriers, consumer groups, and providers of long-term care services regarding: the appropriate inflationary

index to be used with respect to the inflation protection portion of the standards; the uniform needs assessment mechanism to be used in determining eligibility of individuals for benefits under a policy; the appropriate standards for the regulation of the insurance aspects of supported housing arrangements; and other such activities as determined appropriate by the Secretary.

Subpart B. Establishment and implementation of long-term care insurance policy standards

Sec. 2711. Implementation of policy standards

Subsection (a) states that no long-term care insurance policy may be issued, sold, or offered for sale as a long-term care insurance policy on or after the specified date, unless the Secretary determines that the State has established a regulatory program that provides for the application and enforcement of the declared standards established under section 2701(a), and that complies with the requirements of subsection (b) by the specified date in section 2701(b), and the policy has been approved by the State commissioner or superintendent of insurance. Also, no long-term care policy may be sold after the specified date if in the case that the State has not established such a program, or if the State's regulatory program has been decertified, the policy has not been accepted by the Secretary as meeting the standards established under section 2701(a).

The Secretary shall periodically review the regulatory programs. If these programs fail to meet the declared standards, the program will be given a chance to correct the failings. After that time, if the standards are still not met, the Secretary can assume control over the State with respect to certifying policies.

For purposes of subsection (a)(1)(A)(ii), the requirements for a State regulatory program are as follows: there should be notice in the annual report under paragraph (5) to the Secretary of cases where such compliance is not secured within such 30-day period.

The enforcement process under each State regulatory program shall provide procedures for people and entities to file written, signed complaints regarding alleged violation of standards; a timely response to violations; the investigation of the most valid complaints, and other alleged violations of standards; and the imposition of appropriate sanctions against those who have violated the set standards.

The State regulatory program must provide consumers with access to complaints filed, but that access is limited to the extent required to protect the confidentiality of individual policyholders.

Each State program shall provide a process for approving or disapproving proposed premium increases or decreases with respect to long-term care policies, and establish a policy to hear public comments before approving such an increase or decrease. No premium increase, will be approved unless the proposal is accompanied by an actuarial memo which includes a description of assumptions that justify the increase, and contains such information as may be required under the standards, and is made available to the public.

The requirement for the process of approval of premiums does not apply to a group long-term care insurance policy except that

group policies must, pursuant to guidelines developed by the NAIC, provide notice to policyholders and certificate holders of any premium change under such policy. This requirement does not apply to: group conversion policies; the group continuation feature of a group policy if the insurer separately rates employee and continuation coverage; and group policies where the function of the employer is limited solely to collecting premiums and remitting them to the insurer. A State may enact and enforce laws with respect to premium rates or loss ratios for all, including group, long-term care insurance policies.

Each State regulatory program shall submit to the Secretary, an annual report on the implementation and enforcement of the standards in the State.

In a State without a regulatory program, the Secretary shall provide for the enforcement activities under subsection (c). Subsection (c) identifies the procedures that must be included in the regulatory program: file written, signed complaints respecting alleged violations of the requirements of this title; respond on a timely basis to complaints; investigate the most valid complaints of this title and any other violations. While conducting the investigations, the agents of the Secretary shall have reasonable access to enable them to fully examine evidence.

Before serving an order, the Secretary is required to notify the violator, and upon request made within a reasonable period of time (not less than 30 days from the date of the notice), provide for a hearing respecting the violation. The hearing should be conducted before an administrative law judge, and if no hearing is requested, the Secretary's imposition of the order shall constitute a final unappealable order.

Agents of the Secretary and administrative law judge shall have necessary access to the evidence of those being investigated. Administrative law judges may subpoena witnesses and evidence as necessary. In case of noncompliance to a subpoena, an appropriate district court may use an order requiring compliance. Any failure to obey may be punished as contempt in that district court.

After such a hearing, if the administrative law judge finds violations of the title, he shall state his finding, and ask that appropriate action be taken. At that time, the violator should cease any and all acts of noncompliance, and pay a civil penalty in an amount not to exceed \$15,000 in the case of each agent, and \$25,000 in the case of each association, for each violation. In addition, appropriate remedial action may be ordered.

If it is found that the violation was due to reasonable cause and was not intentional or due to neglect, or if corrective action is taken within 30 days, then no penalty will be handed down. In such a case, the Secretary may waive part or all of the civil money penalty, to the extent that payment of such penalty would be grossly excessive relative to the violation involved and to the need for deterrence of violations.

The decision of the administrative law judge shall be the final agency decision and order of the Secretary unless, within 30 days, the Secretary modifies or vacates the decision and order.

Those found guilty of violations may file a petition with the Court of Appeals within 45 days of the finding. If those found

guilty fail to comply with the final order after the opportunity for judicial review, the Secretary shall file suit in any appropriate district court, to seek compliance with the order. In such a suit, the validity and appropriateness of the final order shall not be subject to review.

Sec. 2712. Regulation of sales practices

Subsection (a) relates to the marketing and sale of long-term care insurance policies by agents or associations. The subsection identifies practices that will be considered violations of good faith and fair dealing. Violations of this include: Knowingly making any misleading representation (including inaccurate completion of medical histories) or incomplete or fraudulent comparison of any long-term care insurance policy or insurers for the purpose of inducing a person to retain or effect a change with respect to a policy; employing any method of marketing to induce the purchase of a long-term care policy through force, fight, threat, or undue pressure, whether explicit or implicit; making use directly, or indirectly of any method of marketing which fails to disclose that its purpose is solicitation of insurance.

Subsection (b) directs the NAIC to recommend financial minimum standards for advising individuals purchasing long-term care insurance policies.

Subsection (c) states that any agent, association, or its subsidiary may not knowingly sell or issue a long-term care policy to anyone who is eligible for Medicaid.

Subsection (d) states that an agent or carrier may not sell or issue a service-benefit long-term care insurance policy to an individual knowing that the policy provides for coverage that duplicates coverage already provided in another policy, unless the individual provides a written statement that the coverage does not duplicate other coverage in effect under a service benefit insurance policy. In this subsection, the term "service benefit long-term care insurance policy" means a long-term care insurance policy that provides for benefits based on the type and amount of services furnished.

Subsection (e) prohibits the sale of policies that reduce, limit or coordinate the benefits provided under the policy on the basis that the policyholder has or is eligible for other long-term care insurance coverage of benefits.

Subsection (f) prohibits the sale of long-term care policies unless the agent or carrier provides an outline of coverage meeting certain standards to every individual purchaser or potential purchaser.

Subsection (g) establishes the following penalties for any agent who offers or sells insurance in violation of this title: imprisonment for not more than 5 years; or a civil money penalty not to exceed \$15,000 for each violation. If an association or its subsidiary violates any of these terms, it may be fined with a civil money penalty not to exceed \$25,00 for each violation.

Subsection (h) directs the NAIC to establish requirements for long-term care insurance agent training and certification.

Sec. 2713. Additional responsibilities for carriers

Subsection (a) establishes a requirement that carriers must refund any premiums paid with respect to such policy directly to the applicant if the applicant returns the policy or is denied not later than 30 days after the date of denial or return.

Subsection (b) states that if an application for a long-term care policy is approved, the carrier shall provide every individual applicant a copy of the policy not later than 30 days after the date of the approval.

Subsection (c) requires that if a claim under a long-term insurance policy is denied, within 30 days of the denial, the provider must complete a written explanation of the reason for the denial and make available all related medical and patient records. No claim may be denied on the basis of a failure to disclose a condition at the time if insurance of the policy if the application for the policy failed to request information respecting the condition.

Subsection (d) describes reporting information that carriers of long-term insurance policies shall report to the state director of insurance.

Subsection (e) establishes standards for agent compensation for the sale of long-term care insurance policies.

Sec. 2714. Renewability of standards for issuance, and cancellation of policies

Section 2714 outlines the standards for renewing long-term care insurance policies.

Subsection (a) states that no long-term care insurance policy may be canceled or nonrenewed for any reason other than nonpayment of premium, material misrepresentation, or fraud.

Subsection (b) describes requirements regarding continuation and conversion rights for group policies.

Subsection (c) defines the standards for issuance of long-term care policies. The issuer of such policies shall guarantee coverage to any individual who meets minimum medical underwriting requirements of such policy. The NAIC is directed to establish standards with the respect to access of policyholders to upgraded benefits and for rate stabilization.

Subsection (d) states that long-term care insurance may not be canceled for nonpayment if the policyholder is determined by a long-term care provider, physician, or health care provider independent of the issuer of the policy, to be cognitively or mentally incapacitated so as to not make payments in a timely manner. This subsection also includes terms of cancellation: A plan may be canceled if the period of nonpayment is in excess of 30 days and the notice of intent to cancel is provided to the policyholder or their representative not less than 30 days prior to such cancellation except that the notice may not be provided until the expiration of 30 days after premium is due and unpaid.

Sec. 2715. Benefit standards

Section 2715 elaborates the standards for definitions, terminology, and benefits.

Subsection (a) states that each long-term care insurance policy is to use uniform language, definitions, and format for outlines.

Subsection (b) describes information to be disclosed to all applicants.

Subsection (c) states that a long-term care insurance policy may not condition or limit eligibility for benefits for a kind of services to need for or receipt of any other services; for any benefit on the medical necessity for such benefit; for benefits furnished by licensed or certified providers in compliance with conditions which are in addition to those required for licensure or certification under State law, except that no State licensure or certification laws exist, in compliance with qualifications developed by the NAIC. This subsection also identifies ways in which policies that provide home health care or community-based care may not limit such benefits.

Subsection (c) also states that policies that cover nursing home services must provide coverage for such benefits with respect to all nursing facilities as defined in section 1919(a) of the Social Security Act. A *per diem* long-term care insurance policy is defined as one that provides for benefit payments on a periodic basis due to cognitive impairments or loss of functional capacity without regard to the expenses incurred or services rendered during the period to which the payments relate.

Subsection (d) prohibits any different treatment for benefits under the policy in the case of an individual with Alzheimer's disease or with mental retardation or any other cognitive or mental impairment from an individual having another medical condition for which benefits may be made available.

Subsection (e) sets limits for preexisting condition exclusions and defines terms and conditions for preexisting conditions. A long-term care insurance policy may not exclude or condition benefits based on a medical condition for which the policyholder received treatment or was otherwise diagnosed more than 6 months before the issuance of the policy or for a loss of confinement that begins within 6 months following the effective date of the person's coverage.

Subsection (f) describes the requirements concerning eligibility for benefits.

Each policy must describe the level of benefits available under the policy and specify the impairment levels required in order to receive benefits under the policy. In order to submit a claim, each policyholder shall have a professional functional assessment. Such assessment may not be conducted by an individual who has a controlling interest in the issuing of the policy. Each long-term care insurance policy shall be subject to final claims review except that issues concerning an individual's level of impairment, as determined by a professional assessment, shall be subject to a separate appeal process.

Subsection (g) specifies that each long term care insurance policy must offer the option of inflation protection to policyholders. The subsection further defines the kind of inflation protection that must be offered. Carriers are required to include specific information in the outline of coverage that illustrates the effect of inflation and the impact on the premium cost if a person purchases inflation protection initially or delays purchasing such protection until a later time. The carrier must also allow for increases in benefits that account for anticipated increases in costs of long-term services, and follow guidelines which must be included in the outline of coverage.

Inflation protection must be included unless formally rejected by the policyholder in written form.

Sec. 2716. Nonforfeiture

If a policy lapses after the policy has been in effect for a minimum period, the policy must provide nonforfeiture benefits as determined appropriate by the NAIC; the benefits must increase according to the policyholder equity in the policy.

Sec. 2717. Limit of period of contestability; right to return

A carrier may not cancel or renew a long-term care insurance policy or deny a claim under the policy based on fraud or intentional misrepresentation unless the notice of such is provided within a certain time period to be determined by the NAIC. Each policyholder shall have the right to return the policy within 30 days of the delivery date if not satisfied.

Sec. 2718. Civil money penalty

Any carrier, association, subsidiary or agent that sells long-term care insurance policies and fails to ascribe to the standards set in 2713(a), 2713(b), 2713 (c) or (d), 2713(e), 2715(b)(1), or 2715(f) is subject to a penalty of not to exceed \$25,000 for each such violation; for agents, the fine is not to exceed \$15,000 for each violation.

Subpart C. Long-term care insurance policies, definitions, and endorsements

Sec. 2721. Long-term care insurance policy defined

Subsection (a) defines "long-term care insurance policy" as any insurance policy offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity prepaid or other basis, for one or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than that of an acute care unit of a hospital. These terms include group and individual annuities and life insurance policies or riders that provide directly, or that supplement long-term care insurance; and a policy, rider, or certificate that provides for payment of benefits based on cognitive impairment or the loss of functional capacity.

Subsection (b) states that policies may be used by carriers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, HMO's and any similar organization otherwise authorized to provide insurance. The term "long-term care insurance policy" does not include any insurance policy, rider, or certificate that is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. With respect to life insurance policies, riders, or certificate that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institu-

tional confinement, and that provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon receipt of long-term care.

Sec. 2722. Code of conduct with respect to endorsements

This section directs the NAIC to issue, no later than 1 year after the date of enactment of this part, guidelines to organizations and associations and their subsidiaries, other than employers and labor organizations, that provide endorsements of long-term care insurance policies or permit sale through the organization or association. This section defines the minimum standards to be included in the guidelines.

Part 2. Life care: public insurance program for nursing home care

Sec. 2301. Short title

This section may be cited as the Life Care Act.

Sec. 2302. Life care; public insurance program for nursing home care

Title XXVII of the Public Health Service Act is amended by adding the following new part to create a voluntary public insurance program for nursing home care:

Sec. 2741. Establishment of voluntary insurance program

This section requires the Secretary to establish a voluntary long-term care insurance program for individuals age 35 and over and to establish a process for enrollment.

Sec. 2742. Benefits

This section establishes eligibility for services provided in a nursing facility and provides for nonforfeiture of benefits for which premiums have been paid. Individuals may elect \$30,000, \$60,000, or \$90,000 of coverage. Such amounts will be adjusted to reflect changes in the Consumer Price Index.

Sec. 2743. Eligibility

In order to be eligible for benefits an individual must be determined by a screening agency to either require assistance in 3 or more activities of daily living; or require assistance in at least one instrumental activity of daily living related to cognitive or mental impairment; or have a behavioral problem that creates a need for supervision; or achieve a score on a standard mental status protocol appropriate to measure severe cognitive or mental impairment. Assistance must be expected to be needed for at least 90 days. Eligible individuals also must be legal residents of the United States and file an application for benefits.

Special rules pertain to eligibility in the program's initial year. In this year any individual age 35 or older may purchase coverage, except that individuals who are con-

fined to a nursing home may not purchase coverage within 6 months of such confinement and individuals confined to a hospital may not purchase coverage within 90 days. However, if an individual's confinement in a hospital or nursing home extends beyond the initial year, he or she may enroll during the 60 day period beginning after the individual's spell of illness. Individuals who enroll in the initial year (or under the special extension provision) are subject to a 3 year waiting period to receive benefits.

After the initial year, individuals are entitled to enroll within 6 months of their 35th, 45th, 55th, and 65th birthdays. No individual may receive benefits if they are admitted to a nursing facility within one month of purchasing coverage, unless the need for services is due to an accident or stroke subsequent to the date of enrollment.

In the 12 months preceding the initial enrollment period, the Secretary is required to conduct a public education campaign designed to inform potentially eligible individuals as to the nature of the benefits and the limited enrollment period.

Sec. 2744. Premium rates

This section establishes premium rates for individuals age 35, 45, 55, and 65 (and, during the initial year, actuarially fair, age-rated premiums for individuals over age 65). Such premium rates are to be adjusted annually. Premium rates must be expected to cover 100 percent of the benefits paid under this program.

Individuals are not required to pay premiums for any month in which they receive benefits under this program.

Sec. 2745. Qualified service providers

Only State certified nursing facilities that meet the requirements of this part, and any standards established by the Secretary, are considered qualified service providers.

Sec. 2746. Reimbursement

The program covers 65 percent of the reasonable and appropriate cost of care provided under this program (80 percent during the initial 6 months of coverage). Individuals are required to pay 35 percent of such costs (20 percent during the initial 6 months of coverage). Program and participant payments are to be considered payment in full. Medicare, Veteran's Affairs and private insurance payments for which a covered individual is eligible are considered to be priority payers.

Sec. 2747. Long-term care screening agency

The Secretary contracts with long-term care screening agencies that determine eligibility. Screening agencies must use questionnaires and screening tools developed by the Secretary that measure functional impairments caused by physical or cognitive conditions, behavioral problems, and other criteria developed by the Secretary.

Except for individuals with incomes below 150 percent of the poverty level, screening agencies may require payment from individuals in accordance with standards established by the Secretary.

Sec. 2748. Asset protection

Eligible individuals enrolled in Life Care are allowed to retain a level of assets comparable to the amount of coverage purchased (\$30,000, \$60,000, or \$90,000—adjusted for inflation) under State Medicaid programs.

Sec. 2749. Relation to private insurance

Private insurers may not offer for sale a policy that duplicates coverage provided under Life Care to an individual who has purchased coverage under this part. However, private insurers may offer to covered individuals standard benefit packages, developed by the Secretary, that complement, but do not duplicate coverage under this part.

Sec. 2750. Definitions

This section establishes definitions of nursing facilities and spell of illness.

Sec. 2751. Reports

This section describes reports that the Secretary must prepare both prior to, and not later than 2 years after, promulgation of regulations implementing this act.

Sec. 2303. Sense of the committee concerning PACE

This section expresses the sense of the committee that the number of PACE (Program of All-inclusive Care for the Elderly) sites should be substantially expanded beyond the 15 currently authorized.

Title III. Public Health Initiatives

SUBTITLE A. WORKFORCE PRIORITIES UNDER FEDERAL PAYMENTS

Part 1. Institutional costs of graduate medical education; workforce priorities

Subpart A. National Council regarding workforce priorities

Sec. 3001. National Council on graduate medical education

(a) Establishes the Council on Graduate Medical Education with the Department of Health and Human Services.

(b) Requires the Secretary to carry out subpart B (dealing with the allocation of residency positions among specialties and programs) through the Council.

(c)(1) Specifies that the Council will have between 12 and 18 members. Requires that at least one nurse and one primary care physician be a member of the Council. Specifies the following categories of private sector individuals to be included in the membership of the Council: consumers; medical school faculty; physicians in private practice; officers or employees of health alliances; officers

or employees of health plans; executive officers of teaching hospitals; and others determined to be appropriate by the Secretary. (2) The Secretary shall designate Federal officers or employees as ex officio members of the Council.

(d) Requires the Secretary to designate one member as Chair.

(e) Defines "medical school" as a school of medicine or of osteopathic medicine, referencing section 799 of the Public Health Service Act. Defines "academic health center" as an entity defined in section 3051(c)(1). Defines "National Council" as the council established in subsection (a).

Subpart B. Authorized positions in speciality training

Sec. 3011. Cooperation regarding approved physician training programs.

(a) With respect to funding under section 3031 (subpart C), requires that approved physician training programs enter into agreements that the number of enrollees in their programs will be in accordance with this subpart.

(b)(1) Defines "approved physician training program" as any postgraduate physician training program participation in which may count toward specialty certification. Includes programs based in ambulatory settings whether or not they also provide inpatient hospital services. Defines "eligible program" as approved physician training program receiving funding under subpart C. Includes all medical, surgical and other physician specialties and subspecialties within the term "medical specialty." (2) For the purposes of this subpart, the term "qualified applicant" means an entity that trains individuals in an approved physician program that receives payment under part C for the calendar year in which the academic year begins. (3) For the purposes of this subtitle: The term "academic year" means the 1-year period beginning on July 1; the term "subsequent academic year" means the academic year beginning July of the calendar year for which payments are to be made; the term "funding agreement" means that the Secretary may make payments only to qualified applicants.

Sec. 3012. Annual authorization of number of specialty positions. requirements regarding primary health care

(a) Requires the National Council to designate for each academic year the number of individuals who are authorized to be enrolled in eligible programs.

(b) Requires that at least 55 percent of individuals competing eligible programs nationwide be in primary care, beginning with the class entering training in the year 2000-01.

(c) Requires the National Council to designate the number of positions in each specialty for three academic years at a time, beginning with 2000-01 through 2002-03.

(d) Specifies that the need for additional practitioners in the specialty be included among the factors considered by the National Council in designating specialty positions. Requires the National Council to consider the recommendations of organizations representing physicians in particular specialties and of organizations representing consumers of the services of such physicians. Requires

the National Council ensure that the total number of residency positions nationwide bears a relationship to the number of graduates of U.S. medical schools consistent with the purpose of this subpart, beginning with academic year 2000–01, and is reduced between the years 2000–01 through 2004–05.

(e)(1) The National Council shall establish, no later than July 1, 1996, targets for aggregate number of individuals enrolled in approved physician training programs for each specialty to be achieved by the year 2000. (2) Specialties that meet and continue in compliance with targets established by the National Council will not be subject to the mandatory allocation system in section 3013. (3) To be considered in compliance with the targets set by the National Council, a specialty must demonstrate progress toward reaching the target. (4) The National Council may, at anytime, determine that a specialty is not in compliance with the targets and initiate mandatory allocations.

(f) The Secretary shall arrange for the completion of a study on the effects of medical workforce regulation and planning. The study should be conducted by the Institute of Medicine or a similar entity. The result of the study and recommendations will be sent to the President and the Congress.

(g) Defines for the purpose of this subtitle “annual number of specialty positions”, “designation period”, “specialty position”, and “training participant”. Defines “primary health care” as family medicine, general internal medicine, general pediatrics, geriatric medicine, obstetrics and gynecology, and medical specialties, including psychiatry, that have been designated medical shortage specialties or protected medical specialties.

Sec. 3013. Allocations among specialties and programs

(a) Requires the National Council to allocate the designated annual number of specialty positions nationwide among eligible programs.

(b) Requires that the allocations among programs be done for 3 years at a time, with at least 1 year advance notice to programs, and with the first allocations beginning in academic year 2000–01.

(c)(1) Requires that the historical distribution of specialty positions among different areas of the country and the quality of each of the programs be included among the factors considered in making allocations among programs. (2) Requires that the National Council consider in making allocations for an eligible program the extent to which the program includes training participants who are women or members of racial or ethnic minority groups, and the extent to which such a group is under-represented in the field of medicine or its specialties. (3) Requires that the National Council consider in making allocations for an eligible program the extent to which the program includes training participants from rural or inner-city communities, and the extent to which the program has successfully placed past participants in rural or inner-city communities.

(d) Defines “allocation period” as a 3-year period under (b)(1) for allocations under subsection (a) are made by the National Board.

Subpart C. Institutional costs of graduate medical education

Chapter 1. Operation of approved physician training programs

Sec. 3031. Federal formula payments to qualified entities for the operation of approved physician training programs

Requires the Secretary to make payments for the operation of approved physician training programs, approved pediatric residency programs and approved dental residency programs. Qualified applicant is defined as an entity that trains individuals in approved physician training programs, that submit applications (in accordance with section 3032) beginning in calendar year 1996, and for programs in primary health care specialties, training programs that rotate to community programs in undeserved urban or rural areas.

Sec. 3032. Application for payments

(a) Requires that applications for payment be submitted on a timely basis; contain the described funding agreements and provide assurances of compliance with those agreements that are satisfactory to the Secretary; are in the form and manner and contain information required by the Secretary; and contain agreements by the institution within the program operates that payments will be made directly to the program by the Secretary.

(b) Institutions operating residency programs must these requirements as a condition of participation as providers in alliance health plans.

Sec. 3033. Availability of funds for payments; annual amount of payments

(a) Establishes an annual health professions work force account to contain amounts determined by the Secretary to be necessary for making payments to operate eligible programs and to make transitional payments to programs (under section 3051, dealing with programs that lose residency positions), within the following limitations for specified calendar years: \$3,200,000,000 in 1996; \$3,550,000,000 in 1997; \$4,800,000,000 in 1998; \$5,800,000,000 in 1999; and \$5,800,000,000 in 2000.

(b) Payments to each eligible program shall equal the full-time-equivalent number of residents in the program multiplied by the national average of the costs of training residents (as determined for the academic year 1992–93, trended forward by the consumer price index for each year, and adjusted to reflect regional differences in wage and wage-related costs).

(c) If the annual health work force account available for a calendar year is insufficient for providing each eligible entity with the amount of payments determined under subsection (b), the Secretary shall make pro rata reductions in the amounts so determined as may be necessary to ensure that the total of payments made under section 3031 for such year equals the total of such account.

(d) For purposes of this subtitle the term “annual health professions work force account” means the account established under subsection (a)(1); the term “consumer price index” has the meaning

given in section 1902(11); and the term "general health care inflation factor" has the meaning given in section 60901(a)(3).

Chapter 2. Medical school fund account

Sec. 3041. Federal payments to the medical school fund

(a) The Secretary shall make payments to an eligible medical school for the purpose specified in subsection (b). An eligible medical school must submit an application.

(b) The purpose of the medical school payments is to assist with the direct costs of academic programs including the education of medical students, graduate students in biomedical sciences and unfunded faculty research.

(c) For the purposes of this subpart, the term "eligible medical school" means an approved medical school that submits to the Secretary an application in accordance with section 3043.

Sec. 3042. Application for payments

An application for payment must be submitted by the presiding official of the eligible medical school not later than the date specified by the Secretary, must contain the funding agreement described in this subpart and provide assurances of compliance with agreements, and the applications must be in such form, such manner, and contain such agreements, assurances, and information as the Secretary determines to be necessary to carry out this part.

Sec. 3043. Availability of funds for payments; annual amount of payments

(a) The amount available for an academic year for making payments under section 3041 is for academic year 1996, \$200 million, for academic year 1997, \$300 million, for academic year 1998, \$400 million, for academic year 1999, \$500 million, for academic year 1999, \$500 million, and for academic year 2000, \$600 million.

(b) The amount of payment required is the amount equal to the sum of the product of $\frac{3}{4}$ of the fund account available and the proportion of full-time equivalent students enrolled in eligible medical schools in academic year 1993-94 compared to all full-time equivalent students enrolled in eligible medical schools nationwide in academic year 1993-94; and the product of $\frac{1}{4}$ of the fund account available and proportion of research conducted by the faculty at all eligible medical schools nationwide. The Secretary shall establish a method for measuring faculty research contributions.

(c) The Secretary shall complete two studies. (1) Not later than January 1, 1998, the Secretary shall arrange for an independent study and report on the amount of and allocation method for medical school funding. The study shall be completed by the Institute of Medicine or other similar entity. The report including findings and recommendations on the appropriateness of modifying funding levels or allocation shall be submitted to the President and Congress. (2) Not later than January 1, 2000, the Secretary shall arrange for an independent study and report on the impact of health reform on undergraduate and graduate medical education. The study shall be completed by the Institute of Medicine or other simi-

lar entity. The report including appropriate findings and recommendations shall be submitted to the President and Congress.

(d) For the purposes of this subtitle, the term "annual medical school fund account" means the account established under subsection (a) and the term "general health care inflation factor" with respect to a year, has the meaning given such term in section 6001(a)(3) for such year.

Chapter 3. Academic health centers

Sec. 3051. Federal formula payments to academic health centers

(a) Requires the Secretary to make payments to teaching hospitals and to academic health centers that operate teaching hospitals.

(b) The payments to the teaching hospitals and academic health centers are to assist with specialized costs they incur that are not routinely incurred by other entities in providing health services.

(c) Defines an "academic health center" as an entity that operates a school of medicine or osteopathy, operates or is affiliated with other health professional training programs, and operates or is affiliated with a teaching hospital. Defines a "teaching hospital" as a hospital that operates an approved physician training program (as defined under section 3011). Defines "qualified academic health center" as an academic health center that operates a teaching hospital. Defines "qualified teaching hospital" as any teaching hospital other than a teaching hospital that is operated by an academic health center. For the purposes of this subtitle, the term "eligible institution" means a qualified academic health center, or qualified teaching hospital, that submits to the Secretary a written request in accordance with section 3052.

Sec. 3052. Request for payments

Requires that requests for payment be submitted on a timely basis; contain the described funding agreements; and be in the form and manner and contain such agreements, assurances, and information required by the Secretary. Requires that entities involved agree to maintain their status as a teaching hospital or as an academic health center.

Sec. 3053. Availability of funds for payments; annual amount of payments

(a) Establishes an annual academic health center account that provides for total payments in each calendar year of \$6,280,000,000 in 1996; \$7,250,000,000 in 1997; \$8,220,000,000 in 1998; \$9,400,000,000 in 1999; \$10,640,000,000 in 2000; and in each subsequent year, the amount specified in paragraph (4) increased by the general health care inflation factor (as defined in subsection (d)).

(b) Provides for distribution of such funds among eligible institutions in proportion to the product of their relative gross receipts for patient care and the teaching adjustment factor based on the ratio of full-time equivalent interns and residents to beds. Payments made under this section will be subject to an adjustment factor, as

determined by the Secretary, so that total payments in any year will not exceed the amounts specified in section 3033(a) and as provided in section 3033(c).

(c) Requires the Secretary to report to the Congress by July 1, 2000, with any recommendations for modifying formula payments. In preparing the report the Secretary will consider the costs incurred by academic health centers, the adequacy of the formula payments, the importance to the maintenance of a quality national health care system of academic health centers and the overall impact of health care reform on the ability of academic health centers perform their functions.

(d) Defines the term "annual academic health center account" as the account established in subsection (a). The term "general health care inflation factor" has the meaning given such term in section 6001(a)(3) for such year.

Subpart D. General provisions

Sec. 3055. Definitions

For purposes of this subtitle:

(1) The term "academic year" has the meaning given such term in section 3011(b).

(2) The term "allocation period" has the meaning given such term in section 3013(d).

(3) The term "annual health professions workforce account" has the meaning given such term in section 3033(d).

(4) The term "annual number of specialty positions" has the meaning given such term in section 3012(e).

(5) The term "approved physician training program" has the meaning given such term in section 3011(b).

(6) The term "consumer price index" has the meaning given such term in section 3033(d).

(7) The term "designation period" has the meaning given such term in section 3012(e).

(8) The term "eligible entity" has the meaning given such term in section 3011(b), in the case of subpart B; and has the meaning given such term in section 3031(c), in the case of subpart C.

(9) The term "funding agreement" has the meaning given such term in section 3011(b).

(10) The term "general health care inflation factor" has the meaning given such term in section 3033(d).

(11) The term "medical specialty" has the meaning given such term in section 3001(e).

(12) The term "medical specialty" has the meaning given such term in section 3011(b).

(13) The term "National Council" has the meaning given such term in section 3001(e).

(14) The term "primary health care" has the meaning given such term in section 3012(e).

(15) The term "specialty position" has the meaning given such term in section 3012(e).

(16) The term "training participant" has the meaning given such term in section 3012(e).

Subpart E. Transitional provisions

Sec. 3061. Transitional payments to institutions

(a) The Secretary must make payments to institutions that operate programs that lose specialty training positions as a result of allocations by the National Council.

(b) The Secretary may make payments to an eligible entity only if the entity meets the following conditions: (1) operates or operated one or more programs that are or were at the time of termination an approved physician training program and are or were at the time they terminated receiving payments under section 3031 for such year; and (2) the aggregate number of specialty positions is below the aggregate number of such positions at the entity for academic year 1993-94 as a result of allocations under subpart B, or as a result of voluntary changes under section 3012(e) prior to January 1, 2000. The Secretary may make payments to eligible entity only for the first 4 years after the initial year for which the entity meets the conditions described in paragraph (1). For the purposes of this section, the term "eligible entity" means an entity that submits to the Secretary an application in accordance with subsection (d).

(c) The purpose of the payments is to assist an eligible entity with the costs of operation. The eligible entity is required to enter into a funding agreement with the Secretary that payments will be expended only for approved costs.

(d) Applications for payment must be submitted on a timely basis; contain the described funding agreements and provide assurances of compliance with those agreements that are satisfactory to the Secretary; and be in the form and manner and contain information required by the Secretary.

(e) Payments are equal to the number of full-time-equivalent specialty positions lost (equal to the difference between the positions for which payment will be made under section 3033 and the number of full-time-equivalent specialty positions at the institution for academic year 1993-94 multiplied by the national average salary of training participants (as determined for the academic year 1992-93, trended forward by the consumer price index for each year, and adjusted to reflect regional differences in wage and wage-related costs). For the first year that the programs of the institution experience a net reduction in specialty positions because of the allocations by the Council, payments are to be made over a 4 year period. Payments in the first year are equal to the amount calculated above in the first year, but decline by 25 percent in each of the three succeeding years.

Part 2. Institutional costs of graduate nursing education; workforce priorities

Sec. 3071. National Council; authorized graduate nurse training positions; institutional costs

(a) Establishes a program with respect to graduate nurse training that parallels the program for approved physician training programs under part 1.

(b) Definitions. For purposes of this part:

(1) The term “graduate nurse training programs” means programs for advanced nurse education, programs for education as nurse practitioners, programs for education as nurse midwives, programs for education as nurse anesthetists, and such other programs for training in clinical nurse specialties as are determined by the Secretary to require advanced education.

(2) The term “graduate nurse training position” means a position as an individual who is enrolled in a graduate nurse training program.

(3) The term “programs for advanced nurse education” means programs meeting the conditions to be programs for which awards of grants and contracts may be made under section 821 of the Public Health Service Act.

(4) The term “programs for education as nurse practitioners” means programs meeting the conditions to be programs for which awards of grants and contracts may be made under section 822 of the Public Health Service Act for education as a nurse practitioners.

(5) The term “programs for education as nurse midwives” means programs meeting the conditions to be programs for which awards of grants and contracts may be made under section 822 of the Public Health Service Act for education as nurse midwives.

(6) The term “programs for education as nurse anesthetists” means programs meeting the conditions to be programs for which awards of grants may be made under section 831 of the Public health Service Act for education as nurse anesthetists.

Sec. 3072. Applicability of part 1 provisions

(a) The provisions of part 1, apply to the graduate nurse training program under section 3071 in the same extent and manner as they apply to the graduate physician training programs, except as they are modified in this part.

(b) The National Council on Graduate Nurse Education is established. The composition of the National Council will be the same as the Council in section 851 of the Public Health Service Act.

(c) The National Council will make allocation of nurse training positions in the same way as the Council on Graduate Medical Education does for physician residencies.

Sec. 3073. Funding

The amount available for graduate nurse training programs under this part is \$200 million for each of the calendar years 1996 through 2000.

Part 3. Replated programs

Subpart A. Workforce development

Sec. 3081. Programs of the Secretary of Health and Human Services

(a) Authorizes to be appropriated \$100 million for each of the fiscal years 1995 and 1996, and \$150 million for each of the fiscal years 1997 through 2000 for carrying out the programs described in this section, in addition to amounts otherwise authorized to be

appropriated for such programs. Requires the Secretary of Health and Human Services to carry out the programs in this section.

(b) Establishes new programs and expands existing programs that train primary care physicians and physician assistants including programs to train additional numbers of physicians and physician assistants; to retrain mid-career physicians previously certified in a nonprimary care specialty; to expand the supply of physicians with special training to serve in medically underserved areas; to expand service-linked educational networks for training in community settings; to provide training in managed care, practice management, and continuous quality improvement; and to enhance information on primary care workforce issues.

(c) Establishes or expands programs with that train underrepresented racial and ethnic minorities and disadvantaged persons, including programs to increase the number of such persons in the health professions through financial assistance, recruitment and retention, enhancing interest at the pre-professional level, and training of additional minority health professions faculty.

(d) Establishes programs to increase the number of individuals from rural, underserved areas trained in the health professions and to retain individuals providing health care in rural, underserved areas through: financial assistance; fostering interest at the pre-professional level; developing rural training curricula; establishing locum tenens programs; fostering interdisciplinary team approaches to training and practice; and developing telemedicine systems.

(e) Establishes or expands programs with respect to training of nurses, including training additional numbers of nurse practitioners and nurse midwives; baccalaureate nurses for careers in teaching, community health service and specialized clinical care; nurse clinicians and nurse anesthetists; and school-based community nurses; also programs to promote research on nursing work force issues.

(f) Establishes a program to develop and encourage adoption of model practice statutes for advanced practice nurses and physician assistants, and to support efforts to remove inappropriate barriers to practice by advanced practice nurses and physician assistants.

(g) Establishes an Advisory Board on Health Care Workforce Development to advise, consult and make recommendations to the Secretary and to the Secretary of Labor on health care worker supply and impact of this act on health care workers.

(h) Establishes a programs that train health professionals and administrators in managed care, cost-effective practice management, continuous quality improvement practices, and provision of culturally sensitive care.

(i) This section may be carried out through programs in title VII or VIII of the Public Health Service Act.

(j) Title VII of the Public Health Service Act is amended by adding a new section entitled "Section 779. Mental Retardation and other Developmental Disabilities." The Secretary may make grants and enter into contracts with schools of medicine and schools of dentistry to support projects that provide interdisciplinary training for medical students, residents or practicing physicians and dental students, residents and dental hygienists to deliver primary care to

individuals with mental, physical and developmental disabilities, including mental retardation, particularly those who are more than 18 years of age.

In addition, these entities are supported to develop, evaluate and disseminate curricula, support faculty training and retraining and continuing education activities aimed at providing primary health care services to individuals with mental, physical and developmental disabilities, including mental retardation, particularly those who are more than 18 years of age. The authorization for section 3081(j) is \$10 million for each of the fiscal years 1995 through 2000.

Subpart B. Transitional provisions for workforce stability

Sec. 3091. Application

Provides that provisions of this subpart, which are intended to minimize disruptions to established employment relationships during the period of transition to a restructured health care delivery system, shall terminate December 31, 2000. Limits application of provisions of this subpart to health care entities that employ more than 25 individuals.

Sec. 3092. Definitions

Defines "health care entity," "affiliated enterprise," "preference eligible employee," and "displacement" for purposes of this subpart.

Sec. 3093. Obligations of displacing employer and affiliated enterprises in event of displacement

Requires a health care entity which displaces a preference eligible employee to provide the employee with notice of employment rights under this subpart and notice of existing or subsequent vacancies with the displacing employer or an affiliated enterprise, and requires that any such vacancy remain open for applications by preference eligible employees for 14 calendar days from initial notice.

Provides that a qualified preference eligible employee who applies during the 14-day notice period for a vacant position which is in the employee's occupational specialty and is in the same State or Standard Metropolitan Statistical Area in which the employee was previously employed shall be given the right to accept or decline the position before it is offered to a nonpreference eligible employee, except that where more than one qualified preference eligible employee has applied for a vacancy, the hiring health care entity has discretion as to which employee will be offered the position.

Provides that nothing in this subsection shall be construed to prohibit the hiring health care entity from establishing reasonable employment qualifications for any vacancy, except that employees who performed essentially the same work prior to displacement shall be deemed presumptively qualified for comparable positions.

Provides that a displaced employee's preference eligibility terminates when the employee is rehired by the displacing entity to a substantially equivalent position. If the employee has not been rehired to a substantially equivalent position, the employee's pref-

erence eligibility terminates with respect to affiliated enterprises 2 years from the date of displacement and, with respect to the entity which displaced the employee, at the end of the transition period (December 31, 2000).

Sec. 3094. Employment with successors

Provides that where the identity of the employer changes because of a merger, consolidation, acquisition, or contracting out of work, but the nature of the work being performed is substantially the same, employees have the right to continue in their positions, unless the positions no longer exist.

Sec. 3095. Collective bargaining obligations during transition period

Provides that where a successor employer has taken over the operations of the predecessor employer with no substantial change in operations, and a majority of the employees were represented by a union and covered by a collective bargaining agreement negotiated with the predecessor employer, the successor employer must recognize the employee's union and honor the agreement.

Provides that where employees of a contractor are regularly assigned to perform work on the premises of a contracting entity and perform tasks that are functionally integrated with the operations of the contracting entity, both the contractor and contracting entity shall be considered joint employers of the employees with respect to that work for purposes of labor relations laws, and such employees may not be excluded from a bargaining unit within either entity because of that joint employer status.

Sec. 3096. General provisions

Requires the Secretary of Labor to promulgate regulations to implement the requirements of section 3093.

Provides that nothing in this subpart preempts or excuses non-compliance with any other applicable Federal or State law, regulation or ordinance that establishes additional notice and preference standards or requirements concerning employee dislocation, employee representation or collective bargaining.

Provides that nothing in this subpart excuses or otherwise limits the obligation of an employer to comply with a collective bargaining agreement or employment benefit plan that provides rights to employees in addition to those provided under this subpart, or requires an employer to recognize or bargain with a labor organization in violation of State Law.

Provides that individual rights of employees under section 3093 are enforceable in the manner provided for enforcement of rights under the Family and Medical Leave Act, and that collective bargaining and contractual rights provided under sections 3094 and 3095 are enforceable through existing administrative and judicial procedures provided under State and Federal law with respect to such rights.

SUBTITLE B. ACADEMIC HEALTH CENTERS

Sec. 3131. Contracts for ensuring access to centers

(a) Each State shall ensure that health plans enter into sufficient contracts with Academic Health Centers to ensure that enrollees in health plans receive the specialized treatment expertise and services of such centers.

Sec. 3132

(b) The Secretary is authorized to make grants to rural information and referral systems and community and provider-based plans for the purpose of providing the services of eligible Academic Health Centers to residents of rural or urban communities who otherwise would not have adequate access to such services.

SUBTITLE C. HEALTH RESEARCH INITIATIVES

*Part 1. Programs for certain agencies**Sec. 3201. Biomedical and behavioral research*

Subsection (a) provides the findings of Congress pursuant to health research initiatives and particularly biomedical and behavioral research programs for certain agencies.

Subsection (b) sets forth the availability of funding. Pursuant to section (b)(1) the Secretary shall make available funds for activities under this section in an amount equal to 0.25 percent in 1996, 0.50 percent in 1997, 0.75 in 1998, and 1.0 percent in 1999 and subsequent years, of all private premiums required to be paid under this act.

Subsection (c) sets forth the purposes for the expenditures. Part A of title IV of the Public Health Service Act is amended by adding at the end thereof the following new section:

Sec. 404F. Expenditures for health research

Section 404F(a) allows for the amounts available under section 3201 of the Health Security Act to be distributed by the Secretary. The Secretary shall distribute:

(1) 2 percent of such amounts during any fiscal year to the Office of the Director of the National Institutes of Health to be allocated at the Director's discretion for particular activities specified further in the provision;

(2) 2 percent of such amounts for transfer to the National Center for Research Resources to carry out section 1502 of the National Institutes of Health Revitalization Act of 1993 concerning Biomedical and Behavioral Research facilities;

(3) 1 percent of such amounts during any fiscal year for carrying out section 301 and part D of title IV with respect to health information communications; and

(4) the remainder of such amounts during any fiscal year to member institutes of the National Institutes of Health and Centers in the same proportion to the total amount received under this section, as the amount of the annual appropriations under the appropriations acts for each member Institute and Center for the fiscal year bears to the total amount under ap-

appropriations acts for all member Institutes and Centers of the National Institutes of Health for the fiscal year.

Section 404F(b) requires that the amounts transferred under subsection (a) be allocated by the Director of NIH or the various directors of the institutes and centers, as the case may be pursuant to allocation plans developed by the various councils to such directors after consultation with such director.

Sec. 3202. Health services research

Section 902 of the Public Health Service Act as amended by section 2(b) of Public Law 102-410, is amended by adding at the end of the following subsection:

(f) RESEARCH ON HEALTH CARE REFORM.—

(1) This provision provides that in section 901(b), the administrator shall conduct and support research on the reform of the health care system of the United States, as directed by the National Board.

(2) This provisions set forth the priorities in carrying out paragraph (1), the administrator shall give priority as provided in this section.

Part 2. Funding for program

Sec. 3211. Authorizations of appropriations

Subsection (a) provides for authorization of appropriation pursuant to Health Services Research. For the purposes of carrying out activities pursuant to the amendments made by section 3202, there are authorized to be appropriated \$150 million for fiscal year 1995, \$400 million for fiscal year 1996, \$500 million for fiscal year 1997, and \$600 million for each of the fiscal years 1998 through 2000.

Subsection (b) provides that the authorization of appropriations established in subsection (a) are in addition to any other authorization of appropriations that are available for the purposes described in such subsections.

Subsection (c) provides that no expenditure shall be made pursuant to section 3201(c) during any fiscal year in which the annual amount appropriated for the National Institutes of Health is less than the amount so appropriated for the prior fiscal year.

SUBTITLE D. CORE FUNCTIONS OF PUBLIC HEALTH; NATIONAL INITIATIVES REGARDING PREVENTIVE HEALTH

Part 1. Funding

Sec. 3301. Authorization of appropriations

Section 3301 authorizes for appropriation \$150 million in fiscal year 1995, \$225 million in 1996, \$325 million in 1997, \$425 million in 1998, \$500 million in 1999, and \$625 million in 2000, for grants to States to carry out the core functions of public health. For the purpose of carrying out the National Initiatives Regarding Health Promotion and Disease Prevention there are authorized to be appropriated \$125 million for each of the fiscal years 1996 through 1998 and \$150 million for each of the fiscal years 1999 through 2000. The amounts authorized under this section are in addition to

any other authorizations that are available for the purposes described.

Part 2. Core functions of public health programs

Sec. 3311. Purposes

Section 3311 outlines the purposes of this program to strengthen the capacity of State and local public health agencies to carry out certain functions, including: monitoring and protecting the health of communities against communicable disease, exposure to toxins, occupational hazards, harmful products, and poor quality health care; identifying and controlling outbreaks of infectious diseases, chronic diseases, and injuries; informing and educating consumers and providers about preventing injuries and disease and the appropriate use of medical services; developing and testing new prevention strategies; integrating and coordinating the prevention programs of health plans, community-based providers, local and State health departments, and other related programs; and, conducting research on the effectiveness and cost-effectiveness of public health programs.

Sec. 3312. Grants to States for core public health functions

The Secretary will make grants to States for the purpose of carrying out core functions of public health. Grants are awarded on a formula basis using the same formula that is currently used in the Preventive Health and Health Services Block Grant Programs. States may use these funds for core functions of public health including: population-based health programs; monitoring of health outcomes, including population subgroups; information management; housing, workplace, food and water safety programs; support for poison control centers; assessment and abatement of lead-related health problems; investigation and control of adverse health conditions; public information and education; quality assurance; provision of public health laboratory services; training and education of health professionals; and, community needs assessment. Funds may not be used to provide inpatient services, make cash payments to intended recipients of health services, purchase or improve land, satisfy non-Federal contributions for the receipt of Federal funds, or provide financial assistance to entities other than those that are public or nonprofit private. States may not use more than 10 percent of the grant for administrative purposes, and are required to meet a "maintenance of effort" standard.

Sec. 3313. Submission of information

Section 3313 describes the information that must be submitted by a State in order to qualify for a grant. Such information includes: a description of existing deficiencies in the State's public health system; health status measures to be improved through expanded public health activities; current State and local funding for such functions in the prior fiscal year; and, a description of the core public health functions that will be supported with grant funds.

Sec. 3314. Reports

Section 3314 requires that States submit a report to the Secretary describing the purposes for which the grant was expended and the extent of progress made by the State in achieving measurable outcomes and objectives.

Sec. 3315. Application for grant

Section 3315 specifies that the Secretary may make grants only if a State submits an acceptable application. The application must contain the items required in section 3314, and be in such manner, and contain such agreements, assurances, and information as the Secretary determines to be appropriate.

Sec. 3316. Allocations for certain activities

Section 3316 allows the Secretary to reserve not more than 5 percent of the funds made available to support the following activities: providing technical assistance, including biostatistical, epidemiological, and laboratory expertise; developing and operating a national information network for State and local health agencies; monitoring and evaluating the core functions of public health supported through this program; and, development of a uniform electronic reporting mechanism for States to use in submitting information to Federal agencies.

Sec. 3317. Definitions

Section 3317 states that the term "funding agreement", with respect to a grant under section 3312, means that the Secretary may make the grant only if the State makes the agreement involved. Core functions of public health are defined as those described in section 3312.

Sec. 3318. Single application and uniform reporting systems for core functions of public health and public health programs administered by the Centers for Disease Control and Prevention

Section 3318 establishes a single application and uniform reporting system for certain public health grants administered by the Centers for Disease Control and Prevention (CDC). States and local governments that currently have grants, contracts or cooperative agreements with CDC are eligible to use these new instruments. Eligible grant programs that may be awarded under a single application and that may use a uniform reporting system include: the Core Functions of Public Health Program described in section 3312; the National Initiatives Regarding Health Promotion and Disease Prevention described in section 3331; the Preventive Health and Health Services Block Grant; the Childhood Lead Poisoning Prevention Program; the Sexually Transmitted Diseases Program; the Prevention of Sexually Transmitted Disease-related Infertility Program; the Breast and Cervical Cancer Early Detection Program; the National Program of Cancer Registries, the Injury Control and Prevention Program; the Preventive Health for Prostate Cancer program; and, other relevant programs as determined by the Secretary. The Secretary shall delineate the amounts to be dedicated to each of the programs described above, and the funding allot-

ments for each of these programs must be consistent with the requirements of Federal law.

The single application must be developed and implemented within one year, and the uniform reporting system within two years, of enactment of this act. The single application and uniform reporting system shall use outcomes consistent with the goals of Health People 2000, be developed with resources made available under section 3316, and involve Federal, State and local public health agencies in its development. The Secretary shall request that the Institute of Medicine conduct a study on the effects of consolidating any or all of the eligible programs, alternative methods for implementing such a block grant program, and alternative formulae for allocating State grants. Particular emphasis shall be placed on the potential impact of consolidation on targeted recipients, including women and vulnerable populations. Such alternative formulae shall incorporate measures of health status, population, and degree of poverty. The Secretary shall issue a report in response to this study within one year of its completion.

Part 3. National initiatives regarding health promotion and disease prevention

Sec. 3331. Grants for national prevention initiatives

Section 3331 describes grants to eligible entities, including agencies of State or local government, private nonprofit organizations (including research institutions), and coalitions that link two or more of these groups, to develop and implement innovative, community-based strategies in health promotion and disease prevention. Projects shall: reflect approaches that take into account the special needs and concerns of the affected populations; target the most needy and vulnerable population groups and geographic areas of the Nation; examine links between various preventable health problems; and, establish or strengthen links between public health agencies and health plans, health care providers, and others as appropriate.

Sec. 3332. Priorities

Section 3332 describes priority areas to be funded through this program. The Secretary shall develop a proposed set of priorities for such grants to be published in the Federal Register. A period of 60 days for public comment will be allowed. The Secretary will then publish a list of final priorities. Special consideration will be given to those projects with potential for replication in other communities, that reduce the prevalence of chronic diseases, that prevent violence against women, and that establish community health advisor programs.

Sec. 3333. Submission of information

Section 3333 specifies that a grant under section 3331 may be made only if the applicant submits information that describes the proposed activities and how one or more of the identified priority areas will be addressed. The total amount of Federal funding being request, the geographic area and populations being served, and a procedure for evaluating the program must also be included

Sec. 3334. Application for grant

Section 3334 specifies that the Secretary may make a grant under section 3331 only if an application is submitted pursuant to the requirements outlined by the Secretary.

Subpart B. Development of telemedicine in rural underserved areas

Sec. 3341. Grants for development of rural telemedicine

(a) The Secretary shall award grants for the purpose of expanding access to health care services for individuals in rural areas through telemedicine. Eligible entities include a consortium of at least three of the following community-based settings: community or migrant health centers, local health departments, community mental health centers, nonprofit hospitals, private practice health professionals or other publicly funded health or social services agencies.

(b) The Secretary may make a grant only if an application is submitted pursuant to the requirements outlined by the Secretary

(c) The Secretary shall give preference in awarding grants to applicants that: are health care providers in a rural health care network; can demonstrate broad geographic coverage; use the funds to develop plans for, or establish, telemedicine systems that will link hospitals and other health care providers; provide a broad range of health care applications; and use local matching funds.

(d) Funds may be used for the development of telemedicine networks linking three or more providers.

Sec. 3342. Report and evaluation of telemedicine

Three years after the first grant has been awarded the Secretary shall submit a report to Congress evaluating (1) whether telemedicine expanded access to health care services; (2) the cost effectiveness of telemedicine services; and (3) the quality of telemedicine services delivered.

Sec. 3343. Recommendations on reimbursement of telemedicine

No later than July 1, 1996, the Secretary shall issue regulations on reimbursement for telemedicine services provided under title XVIII of the Social Security Act.

SUBTITLE E. HEALTH SERVICES FOR MEDICALLY UNDERSERVED POPULATIONS

Subpart A. Authorization of appropriation

Sec. 3411. Authorizations of appropriations

(a)(1)(A) For the development of community health plans and networks there are authorized to be appropriated \$52.5 million in fiscal 1995, \$122.5 million in fiscal 1996, \$192.5 million for fiscal 1997, \$157.5 million for fiscal 1998, \$122.5 million for fiscal 1999, and \$52.5 million for fiscal 2000. (a)(1)(b) With respect to awards for federally qualified health centers for the development of community health plans and networks, there are authorized to be appropriated \$97.5 million in fiscal 1995, \$227.5 in fiscal 1996, \$357.5

in fiscal 1997, \$292.5 in fiscal 1998, \$227.5 in fiscal 1999, and \$97.5 in fiscal 2000.

Subpart B. Development of community health groups and health care sites and services

Sec. 3421. Grants and contracts for development of plans and networks and the expansion and development of health care sites and services

(a) The Secretary may make grants for developing community health groups, and expanding and developing new health delivery sites and services.

(c) The Secretary should give priority to proposals in which a greater number of eligible entities and other health care providers are participants in the community health group, except where providers are limited, such as in rural areas.

(e)(3) The term "medically underserved population" means a medically underserved population as designated in the Social Security Act as well as populations in health professional shortage areas as defined in the Public Health Services Act and populations eligible for premium subsidies and cost sharing reductions based on income under Title I.

Sec. 3422. Certain uses of awards

(a) Awards under section 3421 may be spent for the following purposes:

(1) developing the community health group, including entering into contracts with participants;

(2) expansion, development, and operation of health delivery sites and and services.

(b) The Secretary may fund capital costs not to exceed 10 percent of the amounts appropriated to carry out subpart B.

Sec. 3423. Application

Applications to the Secretary are required.

Sec. 3424. Purposes and conditions

Grants are made for the purposes and subject to the conditions under which eligible entities otherwise receive funding to provide health services to medically underserved populations under the Public Health Service Act.

Subpart C. Capital cost of development of community health groups and other purposes

Sec. 3441. Direct loans and grants

(a) There are two new eligible entities: hospitals designated by the Secretary as essential access community hospitals under the Social Security Act and rural primary care hospitals under the Social Security Act. (b)(1) Definition of the capital costs on which loans and grants can be expended. (b)(2) The Secretary will give priority to the renovation and modernization of medical facilities necessary to prevent or eliminate various safety hazards. (c) The principal amount of loans under subsection (a) may cover up to 90

percent of the costs involved; grants under subsection (a) may not exceed 75 percent of the costs involved.

Sec. 3442. Certain requirements

Any loan made will have to meet such terms and conditions as determined by the Secretary.

Sec. 3443. Defaults; Right of recovery

(a) The Secretary may take necessary action, including waiver of regulatory conditions, deferral of loan repayments or other actions as needed to prevent a default on a loan or loan guarantee. The Secretary may also foreclose a loan in default, or waive, for good cause, any right of recovery from a borrower who fails to make payments on a loan. A waiver of the right of recovery does not modify the Secretary's obligation to make payments for a loan that has been sold and guaranteed.

(b) A loan becomes due and payable immediately if a facility for which loan funds have been used is sold within 20 years after the federally financed work on it is completed. The loan becomes due if sale is to an entity not eligible for assistance under the section, or not approved by the Secretary, or if the facility ceases to be a public or nonprofit private entity eligible for assistance. The Secretary may also subordinate or waive the right of recovery and any other Federal interest based on a loan or loan guarantee for capital projects, if such waiver(s) would further the purpose of serving medically underserved populations.

Sec. 3444. Provisions regarding construction or expansion of facilities

(a) The Secretary may provide loans or loan guarantees for the construction, conversion expansion or modernization of a facility, only if the applicant describes the facility site, provides plans and specifications which meet the Secretary's requirements, and demonstrates that title is vested in one or more of the applicants.

(b) An applicant for a loan must make the following agreements:

- (1) Title to the site will be vested in one or more of the applicants;
- (2) Adequate financial support is available for completing and maintaining and operating the facility;
- (3) The construction contract complies with the Davis Bacon Act (relating to payment of laborers); and
- (4) The facility will be available to persons seeking service there, regardless of their ability to pay.

Sec. 3445. Application for assistance

The Secretary may provide assistance only if the applicant files the application in the form and manner prescribed by the Secretary.

Sec. 3446. Administration of programs

The loans and loan guarantees for capital projects must be administered from a centralized unit in the Department of Health and Human Services.

Subpart D. Enabling and supplemental services

Sec. 3461. Grants and contracts for enabling and supplemental services

(a) The Secretary may make grants to qualified community health groups (plans and networks) and to other public and private nonprofit groups that provide services in one or more health professional shortage areas or to medically underserved populations and are experienced in providing services to increase the capacity of individuals to use health services. The grants are to be used to provide enabling services.

(b) Enabling services are transportation, community and patient outreach, patient education, translation services, and other services that would increase the capacity of individuals to use the comprehensive benefits to which the act entitles them.

(c) Supplemental Services are items or services described in section 1106 (mental health and substance abuse) or section 1118 (dental care) that would otherwise be excluded from coverage prior to January 1, 2001.

(d) Grants may be made only if the applicant submits information demonstrating the need for the services, a proposed grant budget and evidence of significant community involvement in the project.

(e) Applications must be filed in a form and manner prescribed by the Secretary, and include agreements and assurances deemed necessary by the Secretary.

Sec. 3462. Authorizations of appropriations

(a) For enabling services, there are authorized to be appropriated \$35 million for fiscal year 1996, \$140 million for each of the fiscal years 1997 through 1999, and \$175 million for fiscal 2000. (b) For Supplemental Services there are authorized to be appropriated \$100 million for fiscal 1995, \$150 million for fiscal 1996, and \$250 million for each of the fiscal years 1997 through 2000. (c) For enabling services with respect to federally qualified health centers, there are authorized to be appropriated \$65 million in fiscal 1996, \$260 million in fiscal years 1997 through 1999, and \$325 million in fiscal 2000.

Part 3. National Health Service Corps

Sec. 3471. Authorization for appropriations

(a) Funds for carrying out subpart II of part D of title III of the Public Health Service Act, and section 3472 of the Health Security Act, are authorized in the following amounts: \$150 million for fiscal year 1996, \$150 million for fiscal year 1997, and \$250 million for each of fiscal years 1998 through 2000. (b) The authorizations of appropriations established in subsection (a) are in addition to any other authorizations of appropriations that are available for the purposes described in subsection (a).

Sec. 3472. Allocation for participation of nurses in scholarship and loan repayment programs

Of the amounts appropriated under section 3471, the Secretary shall reserve such amounts as may be necessary to ensure that, of the aggregate number of individuals participating in the scholarship or loan repayment program, the total number who are being educated as nurse practitioners, nurse midwives, or nurse anesthetists or are serving as nurse practitioners, nurse midwives or nurse anesthetists is increased to 20 percent.

Sec. 3473. Allocation for participation of psychiatrists, psychologists and clinical social workers in scholarship and loan repayment programs

Of the amounts appropriated under section 3471, the Secretary shall reserve such amounts as may be necessary to ensure that, of the aggregate number of individuals participating in the scholarship or loan repayment program, the total number who are being educated as psychiatrists, psychologists, or clinical social workers or are serving as psychiatrists, psychologists, or clinical social workers is increased to 15 percent.

Part 4. Payments to hospitals serving vulnerable populations

Sec. 3481. Payments to hospitals

(a) The Secretary shall make payments to eligible hospitals from funds made available under this part. The amounts specified in subsection (b) must be made available to the Secretary on behalf of eligible hospitals, but payment is not guaranteed to the State in which an eligible hospital is located or to any individual receiving services from the hospital.

(b)(1) The total amount of the payments is \$1.3 billion for the fiscal year in which the general effective date occurs and for each subsequent year.

(2) For any year prior to the general effective date, the amount specified shall equal the aggregate disproportionate share hospitals (DSH) percentage of the amount otherwise available under this section. The aggregate DSH percentage is equal to the percent of total payments to DSH hospitals in all states represented by the payments to DSH hospitals in participating states.

(c) Payments shall be made on a quarterly basis.

Sec. 3482. Identification of eligible hospitals

(a) In order to qualify for payments, a hospital must be located in a participating state. However, a qualifying hospital may continue to receive payments even if the State in which it is located is no longer a participating State.

(b) States shall identify for the Secretary those hospitals that meet the qualification criteria.

(c) In order to qualify, a hospital must have a low income percentage caseload (as defined in section 1923(b)(3) of the Social Security Act) during the base year of not less than 25 percent.

Sec. 3483. Amount of payments

(a) Of total amounts available for payment, 66.66 shall be allocated for low income assistance.

(b) 33.33 percent of the total shall be allocated to hospitals for services and populations that are not covered or eligible under the act. The Secretary shall develop an allocation methodology.

(c) An eligible hospital's low income percentage shall equal the amount of all low income days attributable to the hospital. Low income days equal the total amount of inpatient days multiplied by the hospital's low income utilization rate under Section 1923(b)(3) of the Social Security Act.

Sec. 3484. Base year

The base year is the year prior to the year of the general effective date of this act.

Sec. 3491

Sense of the committee on the importance of community and migrant health centers in the health care system following enactment of this act.

SUBTITLE F. MENTAL HEALTH AND SUBSTANCE ABUSE

Sec. 3510

By January 1, 2001, States are required to achieve the integration of their State and local mental health and substance abuse services with services covered by health plans. Once a State has achieved integration, there are to be no arbitrary limits on care.

States may integrate before 2001 by receiving a certificate of readiness from the Secretary. States may receive a waiver of the integration requirement, if integration is not medically appropriate or feasible and if they ensure that services will be properly coordinated.

Sec. 3511

During the integration process, States are required to submit the following information to the Secretary:

An integration report describing how the State will achieve integration, including a description of how State and local resources currently spent on these services will be used to facilitate integration. States are to submit this report by October 1, 1998.

An annual transition report describing the amount of funds spent for these services by the source of revenue, the amount spent for supportive services, the amount spent for medically necessary services not covered in title I, and the amount spent for services to ineligible individuals.

An annual report on changes in mental illness and substance abuse disorders in each State's prison system, including an estimate of the extent to which denial of treatment of undertreatment in the private system may be contributing to criminal activity.

Sec. 3531

The Secretary is to make grants to States to demonstrate model methods of integrating public mental health and substance abuse services with mental health and substance abuse services covered by health plans. States must at least give priority in such a program for low-income adults with serious mental illness or substance abuse disorders and children with serious emotional disturbance or substance abuse disorders.

Sec. 3532

States must submit plans for delivering the full range of mental health and substance abuse services authorized in title I without arbitrary limits before 2001.

Sec. 3533

The Secretary is directed to consider Medicaid waiver requests in this area in a timely manner.

Sec. 3534

Appropriations of \$100 million for each of fiscal years 1995 through 2000 are authorized for the state demonstration program.

SUBTITLE G. COMPREHENSIVE SCHOOL HEALTH EDUCATION; SCHOOL-RELATED HEALTH SERVICES

Sec. 3601

Establishes the purposes of this Subtitle.

Sec. 3602

Establishes the Healthy Students-Healthy Schools State grant program to develop and integrate comprehensive school health education programs for kindergarten through grade 12.

Sec. 3603

Directs the Secretary to establish an interagency task force to coordinate Federal efforts in school health education and services, and provide technical assistance to States and educators.

Sec. 3604

Directs the Secretary to establish a clearing house to disseminate materials on school health education.

Sec. 3681

Authorizes appropriations for school-related health services grants.

Sec. 3682

Defines eligibility criteria for school health services planning and operational grants.

Sec. 3683

Directs the Secretary to give preference to those grant applicants whose communities show the most substantial level of need for health services among children and youth.

Sec. 3684

Authorizes grants for the planning and development of school-related health services.

Sec. 3685

Authorizes grants for the operation of school health services.

SUBTITLE H. PUBLIC HEALTH SERVICE INITIATIVE

Sec. 3695

Appropriates the amounts authorized in this title.

SUBTITLE I. COORDINATION WITH COBRA CONTINUATION COVERAGE

Sec. 3801

Amends Public Health Service Act and COBA to correspond with this act.

SUBTITLE J. ADDITIONAL PROVISIONS REGARDING PUBLIC HEALTH

Sec. 3901

Creates a grant program for the development and implementation of curricula to prevent domestic violence and to promote women's health.

SUBTITLE K. OCCUPATIONAL SAFETY AND HEALTH

Sec. 3093. Occupational injury and illness prevention

Directs Secretary of Health and Human Services and the Secretary of Labor to work together to develop and implement a comprehensive program of initiatives to prevent occupational injuries and illness.

SUBTITLE L. FULL FUNDING FOR WIC

Sec. 3905

Authorizes and appropriates funds to achieve full funding of this program by 2000.

SUBTITLE M. BORDER HEALTH IMPROVEMENT

Sec. 3908

Authorizes and encourages the President to reach an agreement with Mexico to establish a commission to address border health issues.

Title V. Quality and Consumer Protection

SUBTITLE A. QUALITY MANAGEMENT AND IMPROVEMENT

Sec. 5001. National Quality Council

(a) ESTABLISHMENT.—Not later than 1 year after the date of enactment of this act, the National Health Board shall establish a council to be known as the National Quality Council to oversee a performance based program of quality management and improvement designed to enhance the quality, appropriateness, and effectiveness of health care services and access to such services.

(b) APPOINTMENT.—The National Quality Council shall consist of 15 members appointed by the President, with the advice and consent of the Senate, who are broadly representative of the population of the United States and shall include—

(1) Individuals and health care providers distinguished in the fields of medicine, public health, health care quality, and related fields of health services research. Such members shall constitute at least one-third of the Council's membership;

(2) Individuals representing consumers of health care services. Such members shall constitute at least one-third of the Council's membership; and

(3) Other individuals representing purchasers of health care; health plans; States; and nationally recognized health care accreditation organizations.

(c) DUTIES.—The National Quality Council shall:

(1) Develop national goals and performance measures of quality;

(2) Develop uniform quality goals and performance measures for plans;

(3) Design and oversee national surveys of plans and consumers;

(4) Design and oversee the production of Consumer Report Cards;

(5) Establish and oversee State-based Quality Improvement Foundations; and

(6) Evaluate the impact of the implementation of this act on the quality of health care services in the United States and the access of consumers to such services.

(d) CONSULTATION.—In carrying out these duties, the National Quality Council shall establish a process of consultation with appropriate interested parties.

(e) TERMS.—

(1) IN GENERAL.—Except as provided in paragraph (2), members of the Council shall serve for a term of 4 years.

(2) STAGGERED ROTATION.—Of the members first appointed to the Council under subsection (b), the President shall appoint members to serve for a term of between 1 and 4 years so that no more than one third of the Council seats are vacated each year.

(3) SERVICE BEYOND TERM.—A member of the Council may continue to serve after the expiration of the term of the member until a successor is appointed.

(f) VACANCIES.—If a member of the Council does not serve the full term applicable under subsection (e), the individual appointed to fill the resulting vacancy shall be appointed for the remainder of the term of the predecessor of the individual.

(g) CHAIR.—The President shall designate an individual to serve as the chair of the Council.

(h) MEETINGS.—The Council shall meet not less than once during each 4-month period and shall otherwise meet at the call of the President or the chair.

(i) COMPENSATION AND REIMBURSEMENT OF EXPENSES.—Members of the Council shall receive compensation for each day (including travel time) engaged in carrying out the duties of the Council. Such

compensation may not be in an amount in excess of the maximum rate of basic pay payable for level IV of the Executive Schedule under Section 5315 of title 5, United States Code.

(j) **CONFLICTS OF INTEREST.**—Members of the Council shall disclose upon appointment to the Council or at any subsequent time that it may occur, conflicts of interest.

(k) **STAFF.**—The National Health Board shall provide to the Council such staff, information, and other assistance as may be necessary to carry out the duties of the Council.

(l) **HEALTH CARE PROVIDER.**—For purposes of this subtitle, the term “health care provider” means an individual who, or entity that, provides an item or service to an individual that is covered under the health plan (as defined in section 1500) in which the individual is enrolled.

Sec. 5002. National goals and performance measures of quality

(a) **IN GENERAL.**—The National Quality Council shall develop a set of national goals and performance measures of quality for both the general population and for population subgroups defined by demographic characteristics and health status. The goals and measures shall incorporate standards identified by the Secretary of Health and Human Services for meeting public health objectives utilizing, but not limited to, goals delineated in Healthy People 2000.

(b) **SUBJECT OF MEASURES.**—National measures of quality performance shall be selected in a manner that provides statistical and other information on at least the following subjects:

- (1) Outcomes of health care services and procedures.
- (2) Health promotion.
- (3) Prevention of diseases, disorders, and other health conditions.
- (4) Access to care and appropriateness of care.

Sec. 5003. Standards and performance measures for health plans

(a) **IN GENERAL.**—The National Quality Council shall establish national standards and performance measures for health plans, which may be used to assess the provision of health care services and access to such services, both for the general population and population subgroups defined by demographic characteristics and health status. In subject matter areas with which the National Quality Council determines that sufficient information and consensus exist, the Council shall establish goals for performance by health plans consistent with the national goals and performance measures established under section 5002. These quality measures shall relate to, at a minimum:

- (1) Access to health care services by consumers, including provider to patient ratios, waiting times for appointments, travel distances, and community involvement and outreach.
- (2) Appropriateness of health care services, including failure to provide appropriate services and continuity of care.
- (3) Consumer satisfaction with care and compliance with members rights, including disenrollment, referral, patterns of claims denials and out-of-network utilization patterns.

(4) Quality improvement and accountability, including showing that the plan can continuously monitor and improve the quality of health care provided.

(5) Provider credentialing and competency.

(6) Management of clinical, and administrative and financial information.

(7) Utilization management including criteria for monitoring underutilization, techniques and provider feedback to minimize interference with the provider-patient relationship, and supervision of utilization determinations by qualified medical professionals.

(b) **CERTIFICATION OF PLANS.**—The National Quality Council shall provide information and technical assistance to States on the use of national standards and performance measures in this section for State certification of health plans.

Sec. 5004. Plan data analysis and consumer surveys

(a) **IN GENERAL.**—The National Quality Council shall conduct (either directly or through contract) periodic surveys of health care consumers and plans to gather information concerning the quality measures established in sections 5002 and 5003. The surveys shall monitor consumer reaction to the implementation of this act and, in coordination with relevant data from health plans and other sources, be designed to assess the impact of this act both for the general population of the United States and for populations vulnerable to discrimination or to receiving inadequate care due to health status, demographic characteristics, or geographic location.

(b) **SURVEY ADMINISTRATION AND DATA ANALYSIS.**—The National Quality Council shall approve a standard design for the consumer surveys and sampling of relevant plan data which shall be administered by the Administrator for Health care Policy and Research or such other appropriate entity the Council shall designate on a plan-by-plan and State-by-State basis. A State may add survey questions on quality measures of local interest to surveys conducted in the State. The plan-level survey shall include a subset of consumer survey responses related to consumer satisfaction, perceived health status, access, and such other survey items designated by the Council.

(c) **SAMPLING STRATEGIES.**—The National Quality Council shall approve sampling strategies that ensure that appropriate survey samples adequately measure populations that are considered to be at risk of receiving inadequate health care or may be difficult to reach through consumer-sampling methods, including individuals who—

(1) Fail to enroll in a health plan;

(2) Resign from a plan; or

(3) Are vulnerable to discrimination or to receiving inadequate care due to health status, demographic characteristics, or geographic location.

(d) **SURVEY INTEGRATION.**—To the extent feasible, the consumer and plan surveys shall be integrated with existing Federal surveys.

Sec. 5005. Evaluation and reporting of quality performance

(a) **PERFORMANCE REPORTS.**—

(1) **HEALTH PLAN REPORTS.**—Each State annually shall publish and make available to the public a performance report in a standard format, designated by the National Quality Council, outlining the performance of each health plan offered in the State, on the set of national measures of quality performance in sections 5002 and 5003. The report shall include the results of a smaller number of such measures for health care providers if the available information is statistically meaningful. The report shall also include the results of consumer surveys described in section 5004 that were conducted in the State during the year that is the subject of the report and be based on the data collected and analyzed in section 5004.

(2) **CONSUMER REPORT CARDS.**—The health plan reports shall be summarized in a consumer report card as specified by the National Quality Council and made available by the State to all individuals in the State.

(3) **QUALITY REPORTS.**—The National Quality Council annually shall provide recommendations to the Congress, the National Health Board, and the Secretary a summary report that—

(A) Outlines in a standard format the performance of each State;

(B) Discusses State-level and national trends relating to health care quality; and

(C) Presents data for each State from consumer surveys described in section 5004 that were conducted during the year that is the subject of the report.

(4) **STATE REPORTS.**—The National Quality Council annually shall provide to each State a summary report that—

(A) Outlines in a standard format the performance of each health plan;

(B) Discusses State-level and national trends relating to health care quality; and

(C) Presents data for each health plan from health plan reports and consumer surveys described in section 5004 that were conducted during the year that is the subject of the report.

(d) **PUBLIC AVAILABILITY OF INFORMATION IN NATIONAL PRACTITIONER DATA BANK ON DEFENDANTS, AWARDS, AND SETTLEMENTS.**—

(1) **IN GENERAL.**—Section 427(a) of the Health Care Quality Improvement Act (42 U.S.C. 11137(a)) is amended by adding at the end the following new sentence: “Not later than January 1, 1996, the Secretary shall promulgate regulations under which individuals seeking to enroll in health plans under the Health Security Act shall be able to obtain information reported under this part with respect to physicians and other licensed health practitioners participating in such plans for whom information has been reported under this part on repeated occasions.”.

(2) **ACCESS TO DATA BANK FOR POINT-OF-SERVICE CONTRACTORS UNDER MEDICARE.**—Section 427(a) of such Act (42 U.S.C. 11137(a)) is amended—

(A) By inserting "to sponsors of point-of-service networks under section 1990 of the Social Security Act," and

(B) In the heading, by inserting "Related" after "Care".

Sec. 5006. Development and dissemination of practice guidelines

(a) DEVELOPMENT OF GUIDELINES.—The National Quality Council may advise the Secretary and the Administrator for Health Care Policy and Research on priorities for the development and periodic review and updating of clinically relevant guidelines established under section 912 of the Public Health Service Act.

(b) HEALTH SERVICE UTILIZATION PROTOCOLS.—The National Quality Council shall establish standards and procedures for evaluating the clinical appropriateness of protocols used to manage health service utilization.

Sec. 5007. Research on health care quality

The National Quality Council may make recommendations to the Secretary and the Administrator for Agency for Health Care Policy and Research concerning priorities for research with respect to the quality, appropriateness, and effectiveness of health care.

Sec. 5008. Quality improvement foundations

(a) ESTABLISHMENT.—The National Quality Council shall oversee the operation of quality improvement foundations to perform the duties specified in subsection (c).

(b) STRUCTURE AND MEMBERSHIP.—

(1) GRANT PROCESS.—The Secretary shall, in consultation with the State and the Council, select a number of regional foundations through a competitive grantmaking process. The Secretary shall allow for foundations to serve only one State if a State so requests.

(2) ELIGIBLE APPLICANTS.—Eligible applicants shall meet the following conditions:

(A) The entity shall be a not-for-profit entity.

(B) The entity shall have a board which includes—

(i) representatives of health care providers from throughout the State, including both practicing providers and experts in the field of quality measurement and improvement, which together shall comprise at least one-fourth of the advisory board's membership;

(ii) at least one representative of Academic Health Centers or schools defined in section 799 of the Public Health Service Act, which shall comprise up to one-fourth of the membership;

(iii) representatives of consumers, who shall comprise one-fourth of the membership; and

(iv) representatives of purchasers of health care, health plans, the State, and other interested parties.

(C) STAFFING.—Each entity shall have sufficient, competent staff of experts possessing the skills and knowledge necessary to enable the foundation perform its duties.

(c) DUTIES.—

(1) IN GENERAL.—Each quality improvement foundation shall carry out the duties described in paragraph (2) for the region

in which the foundation is located. The foundation shall establish a program of activities incorporating such duties and shall be able to demonstrate the involvement of a broad cross-section of the providers and health care institutions throughout the region. A foundation may apply for any conduct research described in section 5007.

(2) DUTIES DESCRIBED.—The duties described in this paragraph include the following:

(A) Collaboration with and technical assistance to providers and health plans in ongoing efforts to improve the quality of health care provided to individuals in the State.

(B) Population-based monitoring of practice patterns and patient outcomes, and auditing samples of such data to assure its validity.

(C) Developing programs in lifetime learning for health professionals to improve the quality of health care by ensuring that health professionals remain abreast of new knowledge, acquire new skills, and adopt new roles as technology and societal demands change.

(D) Disseminating information about successful quality improvement programs, practice guidelines, and research findings, including information on innovative staffing of health professionals.

(E) Assist in developing innovative patient education systems that enhance patient involvement in decisions relating to their health care.

(F) Issuing a report to the public regarding the foundation's activities for the previous year including areas of success during the previous year and areas for opportunities in improving health outcomes for the community, and the adoption of guidelines.

(G) Providing notice to the State or appropriate entity if the foundation finds, after reasonable opportunities for improvement, that a provider or plan appears unwilling or unable to successfully engage in quality improvement activities related to the services described.

Sec. 5009. Authorization of appropriations

For the purpose of carrying out this subtitle, there are authorized to be appropriated such sums as may be necessary for fiscal years 1995 through 2000.

Sec. 5010. Role of States in quality assurance

Each State shall—

(1) disseminate to consumers information related to quality and access to aid in their selection of plans in accordance with section 1206;

(2) disseminate information on the quality of health plans and health care providers contained in reports of the National Quality Council under section 5005(c);

(3) ensure through collaboration with the Quality Improvement Foundation that performance and quality standards are continually improved; and

(4) ensure that educational programs are developed in cooperation with quality improvement foundations to assist consumers in using quality and other information in choosing health plans.

Sec. 5011. Role of health plans in quality management

Each health plan shall—

(1) measure and disclose performance on quality measures as designated by this Act;

(2) furnish information required under subtitle B of this title and provide such other reports and information on the quality of care delivered by health care providers who are members of a provider network of the plan (as defined in Section 1502 (h)(3)) as may be required under this act; and (3) maintain quality management systems that—

(A) use the national measures of quality performance developed by the National Quality Council under section 5003; and

(B) measure the quality of health care furnished to enrollees under the plan by all health care providers of the plan.

Sec. 5012. Information on health care providers

Each State shall make available to consumers, upon request, information concerning providers of health care services or supplies. Such information shall include—

(1) the identity of any provider that has been convicted, under Federal or State law, of a criminal offense relating to fraud, corruption, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of a health care service or supply;

(2) the identity of any provider that has been convicted, under Federal or State law, of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care service or supply;

(3) the identity of any provider that has been convicted, under Federal or State law, of a criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; and

(4) the identity of any provider whose license to provide health care services to supplies has been revoked, suspended, restricted, or not renewed, by a State licensing authority for reasons relating to the provider's professional competence, professional performance, or financial integrity, or any provider who surrendered such a license while a formal disciplinary proceeding was pending before such an authority, if the proceeding concerned the provider's professional competence, professional performance, or financial integrity.

Sec. 5013. Conforming amendments to Public Health Service Act

Technical conforming amendments are made to the Public Health Service Act.

SUBTITLE B. INFORMATION SYSTEMS, PRIVACY, AND ADMINISTRATIVE
SIMPLIFICATION

Part 1. National Health Care Data Network

Subpart A. Purpose and definitions

Sec. 5101. Purpose

Describes the purpose of the National Health Data Network.

Sec. 5102. Definitions

This part provides general definitions for the title, as follows:

Clearinghouse—A private entity certified to process non-standard health care data into standard data or store data and make it available to other entities.

Indexing System—A public or private entity certified to store standard index markers.

Health Care Data Network—The health information system that is formed through the requirements of this subtitle.

Health Care Provider—For this subtitle, health care providers include physician, laboratories, suppliers, and any person furnishing health care.

Health Information Protection Organization—A private or State-operated entity that can access information in the network and process it into nonidentifiable health information.

Health Plan—As in title I and includes workers compensation and automobile insurance insofar as they relate to medical benefits.

Index Marker—Data that indicate the location of specific standard health care data and information necessary to access it.

Non-Identifiable Health Information—Health care data that is not protected health information.

Protected Health Information—Information that is identifiable to a specific individual.

Standard—When referring to a transaction or to data, “standard” means the transaction or data set meets the standards established by the Board.

Subpart B. Requirements on health care providers and health plans

Sec. 5103. Requirements with respect to certain transactions and data

Providers and plans must use the standards established by the Board for all financial, administrative and quality-related transactions and for reporting data required under this act.

Providers must make required quality data available to the network either directly, through a clearinghouse, or through a health plan. Both providers and plans must make certain data available to the government.

To satisfy these requirements, a provider or health plan may directly transmit standardized data or may submit nonstandard data to a certified health care data clearinghouse for processing into standard data and transmission.

Sec. 5104. Availability of standard health care data

Health care providers and health plans must be capable of disclosing all standard health data under section 5103 when such disclosure is authorized under part 2 of this subtitle.

Sec. 5105. Timetable for compliance with requirements

Plans and providers must comply with data and transaction standards 12 months after they are established. When new data elements are required, compliance is required 12 months after the standards are set. If a standard is modified, the Board determines how soon compliance is required (which could range from 90 days to 12 months).

Sec. 5106. Preemption of State "Quill Pen" laws

State laws that require medical or health plan records, including billing information, to be kept in written, rather than electronic form, are preempted, except where the Board determines that such a provision is necessary to prevent fraud and abuse or for some other purpose.

Subpart C. Standards and certification for indexing systems and clearinghouses

Sec. 5108. Establishment of standards

The Board establishes standards for operation of indexing systems and clearinghouses. The standards will ensure these entities cooperate with one another in forming, operating and developing a national network; meet the privacy requirements in part 2; do not take unfair economic advantage of health plans and providers; make public certain performance indicators; and have the highest security procedures practicable.

Sec. 5109. Certification procedure

Not later than 12 months after enactment, the Board establishes a certification procedure for indexing systems and clearinghouses. The procedure includes periodic audits and recertification.

Certification is automatically terminated if an entity violates a privacy requirement under part 2 (unless the Board determines otherwise), and can be terminated for any other requirement for which a penalty is applied.

Sec. 5110. State operation of indexing systems and health care data clearinghouses

States may operate indexing systems and/or clearinghouses and may require each plan or health care provider in the State to use the State index and/or clearinghouse.

Sec. 5111. Ensuring availability of data

If health plans and providers in a State do not have adequate access to certified indexing systems and clearinghouses, the Board shall establish procedures to ensure required data can be made available to the health care data network.

Subpart D. Standards for transactions, data elements, and index markers

Sec. 5112. General requirements on board

The Board must establish standards that are consistent with the objective of reducing costs of providing and paying for health care. To ensure timely implementation of the network, initial standards will, to the maximum extent practicable, incorporate standards that are in use and generally accepted or that are recommended by nationally recognized standards setting groups.

Sec. 5113. Financial and administrative transactions

The Board establishes standards for financial and administrative transactions including eligibility; payment and remittance advice; claims; encounter; claims status; coordination of benefits; first report of injury; claim attachments; referrals, certification and authorization; and any other transactions determined appropriate.

Sec. 5114. Elements of health care data

The Board sets standards to ensure that required data elements are transmittable through the network. The Board also establishes a system to provide for a unique identifier for each individual, employer, health plan, and health care provider.

Sec. 5115. Index markers

The Board sets standards necessary for providers and health plans to transmit index markers for required health care data to a certified indexing system to ensure that data can be located on the network.

Sec. 5116. Timetables for establishment

Within 9 months of enactment, the Board must set standards for financial and administrative transactions and data, enrollment data, government-required data, and index markers. Within 24 months of enactment, standards for quality data, and claims attachment transactions and data must be established. Within 7 years of enactment, standards for transmission of complete computerized patient medical records must be established.

Subpart E. Accessing health care data

Sec. 5117. Accessing financial and administrative data in connection with a financial and administrative transaction

The Board establishes technical standards for providers and health plans to access financial and administrative data through entities in the network only in connection with a financial and administrative transaction and only when this access is authorized under the privacy requirements under part 2.

Sec. 5118. Accessing data for authorized purposes

The Board establishes technical standards that entities must meet to handle requests for data other than financial and administrative transactions.

Sec. 5119. Health information protection organizations

The Board sets standards for the operation of health information protection organizations that are private entities or an entity operated by a State that can access data in the network. These entities may only disclose data if the data is not protected data or if such disclosure is authorized under the privacy requirements under part 2.

With 12 months of enactment, the Board establishes a process for certification, audit and recertification of the entities. Certification is automatically terminated if an entity violates a privacy requirement under part 2 (unless the Board determines otherwise), and can be terminated for any other requirement for which a penalty is applied.

Sec. 5120. Access by the Board and other Federal agencies

The Board may access data through the network only when authorized under the privacy requirements under part 2. Health information protection organizations must make data available to the Board pursuant to a cost reimbursement contract (as defined under Federal Acquisition Regulation).

Health plans and providers must supply data required to comply with this act to a health information protection agency at no charge. Health data accessed by the Board can only be disclosed as authorized under this act including the privacy requirements under part 2. The Board shall make nonidentifiable information available to private, not-for-profit organizations for public use functions.

Sec. 5121. Access by the States

The Board sets standards for the States to access health care data. Certified health information protection organizations make data available to the States pursuant to a cost reimbursement contract (as defined under Federal Acquisition Regulation).

Sec. 5122. Length of time data should be accessible

The Board sets the length of time that health plans and providers must keep data accessible through the health care data network.

Sec. 5123. timetables for establishment of standards and compliance

Within 9 months, the Board sets standards under this subpart which are effective upon establishment. The Board may review and modify those standards.

Subpart F. Penalties

Sec. 5124. Penalties for failure to comply with requirements and standards

Except as provided in section 5125, an entity that violates a standard faces a penalty of up to \$1,000 per violation. Penalties do not apply if the failure is due to reasonable cause and not to willful neglect and the failure to comply is corrected within 30 days.

Penalties do not apply if it is not possible for the person to comply. In these cases, the Board will provide technical assistance to

the provider or health plan. Any penalty may be reduced or waived by the Board if the penalty would be excessive relative to the compliance failure.

Sec. 5125. Penalties relating to accessing data

Penalties for violating sections 5117, 5118, and 5119 are set at not more than \$50,000 and imprisonment of not more than 1 year or both. If the offense is committed under false pretenses, the penalty is \$100,000 and imprisonment of not more than 5 years or both. If the offense is committed with intent to sell, transfer, or use health care data in violation of those sections for commercial advantage, personal gain, or malicious harm the penalty is not more than \$250,000 and imprisonment of not more than 10 years or both.

Subpart G. Miscellaneous

Sec. 5126. Imposition of additional requirements

Health plans and providers are prohibited from imposing additional data requirements on one another except on a voluntary basis or if a waiver is granted by the Board.

Sec. 5127. Rules regarding coordination of benefits

Within 9 months, the Board develops rules and procedures that apply to health plans when benefits are payable under two or more health plans.

Sec. 5128. Effect on State law

State laws which conflict with provisions in the part are preempted with the exception of State laws that provide for State-run health data networks.

Sec. 5129. Health care data continuity

Data held by a health plan or provider that ceases to function is obtained by the State which is responsible for ensuring that the data is transferred to an appropriate health plan or provider chosen by the applicable enrollee. If an indexing system or health care data clearinghouse ceases to function and the existence of their health care data is threatened, the data is transferred to an appropriate certified indexing system or clearinghouse designated by the Board.

Sec. 5130. Protection of commercial information

The Board shall ensure that entities operating the data network do not have to release confidential commercial information to third parties except for uses described in this title.

Sec. 5131. Authorization of Appropriations

Authorization of funding for this subtitle are set at such sums as may be necessary.

Subpart H. Assistance to the Board

Sec. 5132. General requirement on Board

The Board relies on recommendations of the Health Care Data Advisory Panel in consultation with appropriate Federal agencies.

Sec. 5133. Health care data advisory panel

A Health Care Data Advisory Panel is appointed by the President to provide assistance in complying with the requirements under this part and part 2.

Subpart I. Demonstration projects for community-based clinical information systems

Sec. 5135. Grants for demonstration projects

A grant program is established for demonstration project to promote the development and use of electronically integrated community-based clinical information systems. Projects must use existing technology, enhance or integrate telecommunications or information systems already in operation and grantees must be able to fund 50 percent of the cost of the project.

The Board annually reviews grantees to determine if they are complying with the provisions of this subpart and sets sanctions that may be imposed for violations and must include a description of the activities carried out under this subpart in the annual report created under section 1705 of the Public Health Service Act.

Subpart J. Health Security cards

Sec. 5136. Health security cards

Health Security cards may be used only for obtaining benefits under a health plan, a supplemental benefit policy or cost sharing policy, a Federal employee benefit plan supplemental policy, a FEHBP Medicare supplemental policy, or other program specified by the Board. The Board must issue regulations establishing standards for the use of cards and for the information encoded in the cards. The Board must register the name and other features of the security card as a trademark.

Part 2. Privacy of information

Subpart A. Short title, findings, and purposes

Sec. 5160. Short title

This part may be cited as the "Health Care Privacy Protection Act".

Sec. 5161. Findings and purposes

The purpose of this part is to establish uniform Federal standards to protect individual's medical privacy.

Subpart B. Judicial proceedings

Sec. 5162. Privacy of personally identifiable health information

Establishes a federal criminal violation for wrongful disclosure of personally identifiable health care information and provide penalties of up to 1 year imprisonment and a \$50,000 fine for knowing violations; up to 5 years imprisonment and \$100,000 fine for offenses committed under false pretenses; and up to 10 years imprisonment and \$250,000 fine for offenses committed for commercial advantage, personal gain or to harm maliciously.

A criminal offense is also created to protect against individuals being required to misuse their health security card of unique identifier number for a purpose other than obtaining health care or arranging for payment. This is to prevent the health security card from becoming used as a national identification card or becoming a source of personal identification for purposes other than health care.

Sec. 5163. Definitions

Provides definitions for terms used in this part, including "health information trustee" and "protected health information".

Sec. 5164. General limitations of disclosures

All health information that could reasonably be related to a specific individual is to be protected and comprehensive protections are to apply regardless of the form or medium in which the information is stored.

Permitted disclosures are limited to the minimum amount of information necessary to accomplish the particular purpose.

Sec. 5165. Authorizations for disclosure to protected health information

Procedures are outlined prevent consent to disclosure from being a routine execution of a form. Information regarding the intended use of the disclosure and limitations thereon are required and revocations of authorizations are expressly allowed.

Sec. 5166. Treatment; financial and administrative transactions

For purposes of treatment by a health care provider, limited and necessary protected health information may be disclosed so long as the individual has not objected to such disclosure. To the limited extent necessary to fulfill its payment and administrative functions, a health plan may receive protected health information.

Sec. 5167. Oversight

For purposes of oversight and, in particular, health care fraud investigations, protected health information may be disclosed. This provision is intended to facilitate the uncovering of fraud and abuse without allowing personally identifiable health information to be searched for general use against the individual.

Sec. 5168. Next of kin and directory information

This section permits health care providers to share protected health care information with next of kin provided the patient has not objected and allows hospitals to confirm the general health status of a patient when to do so would not reveal protected health information about the patient.

Sec. 5169. Public health

This section permits the limited disclosure of protected health information to a public health authority for disease or injury reporting, public health surveillance, and public health investigations or interventions.

Sec. 5170. Emergency circumstances

This section permits the limited disclosure of protected health information needed to protect the health of an individual from imminent harm in a medical emergency.

Sec. 5171. Judicial and administrative purposes

This section permits the limited disclosure of protected information in accordance legal proceedings in which a party has put his or her physical and mental condition in issue, in connection with an examination ordered by a court or pursuant to a law requiring the reporting of specific medical information to law enforcement authorities.

Sec. 5172 Health research

For purposes of health research projects in connection with which an institutional review board has determined that the project requires protected health information, disclosure of such information is permitted under restrictive conditions to protect the privacy of those whose information is being used. Moreover, an individual must be given notice and an opportunity to refuse to be included in research projects that will include direct contact between the researcher and the individual.

Sec. 5173. Law enforcement

For purposes of the investigation or prosecution of a health care provider or plan or for identification of a victim or witness in a law enforcement inquiry, disclosure of protected health information is permitted. Additional disclosure is restricted.

Sec. 5174. Subpoenas and warrants

Circumstances in which subpoenas or warrants may issue for protected health information are identified and restrictions on additional disclosure of information produced in response to judicial authority specified.

Sec. 5175. Access procedures for law enforcement subpoenas and warrants

A probable cause standard of reason to believe the protected health information is relevant to a law enforcement inquiry is established along with other requirements.

Sec. 5176. Challenge procedures for law enforcement subpoenas

Individuals whose protected health information is being subpoenaed are accorded notice and an opportunity to be heard in opposition to disclosure by way of a motion to quash. The individual bears the burden of demonstrating that his or her privacy interests outweigh the need established by the government authority for access to the information.

Sec. 5177. Access and challenge procedures for subpoenas other than law enforcement subpoenas

The burden of demonstrating a need for protected health information is placed upon a private party seeking such information. Individuals whose protected health information is being sought are entitled to notice and an opportunity to be heard to quash private subpoenas for their protected health information.

Sec. 5178. Security

Health information trustees are required to establish and maintain safeguards for protected health information.

Sec. 5179. Inspection of protected health information

Individuals are given the right to inspect and obtain a copy of their protected health information.

Sec. 5180. Amendment of protected health information

Individuals are given the rights to request amendment of their health information and to have their statement of disagreement with the information in their medical records included therein.

Sec. 5181. Accounting for disclosures

Health care providers and plans are required to maintain an accounting of the disclosures they make from protected health information, which accounting is to be available to the subject of the protected health information.

Sec. 5182. Standards for electronic documents and communications

The National Health Board is to promulgate standards with respect to electronic records and for the electronic substitute for a written signature.

Sec. 5183. Rights of incompetents

The privacy rights of an individual who is declared to be incompetent are to be exercised by that individual's representative. If an individual is otherwise incapable of exercising his or her rights under this bill, the individual's next of kin may exercise those rights.

Sec. 5184. Rights of minors

The rights of those under 18 not legally capable of exercising their rights under state law are to be exercised by their parents or legal guardians.

Sec. 5185. No liability for permissible disclosures

Disclosures permitted by law are not to be a basis for liability.

Sec. 5186. No liability for institutional review board determinations

Members of institutional review boards making determinations in good faith regarding health research are not to be subject to liability.

Sec. 5187. Good faith reliance on certification

Health information trustees who rely upon a certification by a government authority are not to be liable for disclosures.

Sec. 5188. Civil penalty

The National Health Board is authorized to impose civil penalties of up to \$10,000 for substantial failures to comply with the provisions of this bill.

Sec. 5189. Civil action

An express private right of action is provided to remedy invasion of health privacy, which action includes the possibility of liquidated damages of \$5,000, punitive damages and the reimbursement of reasonable attorney's fees and expenses.

Sec. 5190. Relationship to other laws

This bill is not intended to preempt State public health laws that prevent or regulate disclosure of protected health information, laws call for the reporting of vital statistics, laws requiring the reporting of abuse or neglect, Federal law relating to notifications of emergency response employees of possible exposure to infectious diseases or Federal law and regulation governing confidentiality of alcohol and drug patient records.

Sec. 5191. Prior written consent

Unless otherwise specified in this part, prior written authorization must be obtained before disclosing individually identifiable health information.

Sec. 5192. Provider identifiable data

The Board will establish standards for the protection of provider-identifiable data.

*Part 3. Interim requirements for administrative simplification**Sec. 5195. Standard benefit forms*

Within a year after enactment the Board must develop and publish in the Federal Register standardized forms for: enrollment and disenrollment; clinical encounters; and benefit claims.

Within 270 days of publication health providers must use the forms to file claims for payment. Health plans are also required to use the standardized enrollment, claims payment, and clinical encounter forms.

Standards with respect to uniform claims forms be effective until the Board determines the health care data network is operation.

SUBTITLE C. REMEDIES AND ENFORCEMENT

Subtitle C sets forth the remedies available to parties seeking to enforce rights created under the Health Security Act.

Sec. 5201

Defines health care "claims" and describes the general process under which health plans will deal with such claims, including procedures for urgent requests.

Sec. 5202

Provides for the establishment of complaint review offices in each State and sets forth a procedure for consumers to file a complaint based on a health plan's denial of a claim.

Sec. 5203

Lists three options for consumers once they have filed complaints in the Complaint Review Office: they may forgo further proceedings in the Review Office and pursue the claim in any court of competent jurisdiction; they may submit the complaint under an Early Resolution Program in the Complaint Review Office; or they may proceed to a hearing in the Complaint Review Office.

Sec. 5204

Sets forth a process for hearings in the Complaint Review Office. Hearing Officers shall render decisions within 120 days of the filing of a complaint.

Sec. 5205

Establishes a Federal Health Plan Review Board, consisting of five members appointed by the Secretary of Labor. The decisions of Hearing Officers in Complaint Review Offices around the country may be appealed to the Board for review. Decision of the Review Board, in turn, may be appealed to the U.S. Court of Appeals for the circuit in which the violation is alleged to have occurred or in which the complainant resides. Decisions of the circuit court are subject to review by the U.S. Supreme Court upon writ of certiorari or certification pursuant to 28 U.S.C. 1254.

Sec. 5206

Provides authority to the Secretary of Labor to assess civil penalties against plans for unreasonable denial or delay in the payment or provision of benefits, and provides for higher penalties upon a finding that the plan engaged in a pattern or practice of such violations.

Sec. 5211

Requires each State to establish Early Resolution Programs in the Complaint Review Offices within the State.

Sec. 5212

Describes the disputes that may be submitted to the Early Resolution Program and the terms of participation in the Program.

Sec. 5213

Describes mediation proceedings under the Early Resolution Program.

Sec. 5214

Provides that the findings of the Early Resolution Program mediator are advisory in nature and nonbinding, but that a settlement agreement reached by the parties pursuant to mediation is an enforceable contract.

Sec. 5215

Provides that settlement agreements are enforceable in any court of competent jurisdiction.

Sec. 5216

Requires each health plan to establish and utilize publicly available standards for contracting with and dismissing or filing to renew contracts with health care providers. Requires reasonable notice to providers of a decision to dismiss or fail to renew the contract of a provider, and offers the opportunity for a review of the plan's decision by a panel consisting of the provider's peers and, upon consent of the provider and the plan, one or more enrollees in the plan.

Sec. 5231

Provides States with the right to obtain judicial review of determinations by the National Health Board.

Sec. 5232

Immunizes Health Board determinations respecting any matter under subtitle A of title VI from administrative or judicial review.

Sec. 5233

Vests jurisdiction in the Federal district courts for the enforcement of civil monetary penalties assessed by the Secretaries of Labor and Health and Human Services.

Sec. 5234

Establishes priority for the collection of civil monetary penalties in bankruptcy proceedings.

Sec. 5235

Establishes a private right of action to enforce state responsibilities under the Health Security Act.

Sec. 5236

Establishes a private right of action to enforce certain federal responsibilities under the Health Security Act.

Sec. 5237

Establishes a private right of action to enforce the responsibilities of purchasing cooperative, large group sponsors and health plans under the Health Security Act.

Sec. 5237A

Establishes administrative enforcement procedures for plans that fail to comply with the duties imposed on them pertaining to financial solvency and quality assurance.

Sec. 5238

Provides for the enforcement of anti-discrimination protections set forth earlier in title I of the Health Security Act.

Sec. 5239

Defines Federal payments to health plans as Federal financial assistance for purposes of anti-discrimination statutes.

Sec. 5240

Establishes a process for essential community providers to enforce protections provided to them under the Health Security Act.

Sec. 5241

Establishes the exclusive process for bringing a facial constitutional challenge against the Health Security Act.

Sec. 5242

Clarifies that a health plan may sue or be sued under this act as an entity, describes the process for service of legal documents on a health plan, and makes clear that any money judgment against a plan shall be enforceable only against the plan as an entity and not against an individual person.

Sec. 5243

Clarifies that nothing in this title shall be construed to deny, impair or otherwise adversely affect a right or remedy available under law to any person on the date the act is enacted, except to the extent that the right or remedy is inconsistent with the title.

SUBTITLE D. MALPRACTICE REFORMS

Subtitle D provides for a number of reforms to the medical malpractice liability system.

Sec. 5301

Describes the applicability of the malpractice reforms included in this subtitle and defines key terms.

Sec. 5302

Requires each State to adopt at least one alternative dispute resolution mechanism for medical malpractice claims arising from the provision (or failure to provide) health care services to individuals enrolled in a health plan. Permissible alternative dispute resolution methods for use by the States shall be specified by the National Health Board. Such methods shall include at least one of the following: Nonbinding arbitration, voluntary binding arbitration or claims falling below a threshold amount, mediation, early neutral evaluation or a certificate of merit requirement. A State may be granted the authority by the Board to adopt alternative dispute

resolution mechanism other than those specified by the Board if such mechanism satisfies the standards set forth in section 5302(c)(2).

Prior to or immediately following the commencement of a medical malpractice action, the parties are required to participate in the alternative dispute resolution mechanism adopted by the relevant State. Except with respect to claims involving voluntary binding arbitration, a plan enrollee dissatisfied with the final determination reached through any alternative dispute resolution mechanism retains their constitutionally protected right to seek further redress in court. The results of any alternative dispute resolution procedure are inadmissible at any subsequent trial, as are all statements, offers, and other communications made during such procedures unless admissible under State law.

Sec. 5303

Limits the amount that an attorney who represents a plaintiff in a medical malpractice liability action on a contingency fee basis may charge, demand, receive or collect for services rendered in connection with such action to 33 and $\frac{1}{3}$ percent of the first \$150,000 of a judgment or settlement and 25 percent of any amount in excess of \$150,000.

Section 5304 also requires the plaintiffs expenses (including such expenses as expert witness fees, discovery costs, and other typical litigation expenses) to be paid prior to and independent of calculating the contingency fee.

Sec. 5304

Requires that the total amount of damages recovered by a plaintiff in a medical malpractice liability action be reduced by the amount of any payment which the plaintiff has received or is entitled to receive from a "collateral source" on account of the same injury for which damages are awarded, less (1) the amount of any premiums or other payments made by the plaintiff to be eligible to receive the collateral payment and (2) any portion of the award subject to a subrogation lien or claim. If the award is subject to a subrogation lien or claim, the court may reduce such lien or claim by an amount equal to the reasonable costs incurred by the plaintiff to secure the award. The plaintiff is also entitled to recover any costs associated with securing the award subject to the lien or claim.

Section 5305 does not apply if the court determines that the reduction of damages would compound the effect of any State law limitation on damages so as to render the plaintiff less than fully compensated for his or her injuries.

Sec. 5305

Grants the court the discretion to instruct the trier of fact to award any future damages on an appropriate periodic basis. If such an instruction is made, the court may require the defendant to purchase an annuity or other security instrument adequate to assure payments of future damages. Section 5306 also (1) allows the claimant to petition the court for an order requiring that the remaining balance of any future damages be discounted to represent

value and paid in a lump sum should the defendant fail to make payments in a timely fashion or become (or be at risk of becoming) insolvent and (2) grants the court the authority to modify the payment schedule based on changed circumstances.

Sec. 5306

Makes explicit that nothing in this subtitle shall be construed to preempt any State law that sets a maximum limit on total damages.

Sec. 5311

Establishes a grant program for State malpractice reform demonstration projects. Grants may be awarded to test the effectiveness of no-fault liability, enterprise liability and practice guideline systems.

SUBTITLE E

Part 1. Improved enforcement

Sec. 5401. All payer health care fraud and abuse control program

The Secretary of the Department of Health and Human Services (hereafter referred to as the "Secretary") and the Attorney General would jointly establish a program to:

Coordinate Federal, State, and local law enforcement programs to control health care fraud and abuse;

Conduct investigations, audits, and inspections related to the control of health care fraud and abuse; and,

Facilitate enforcement of this subtitle and other statutes applicable to health care fraud and abuse.

Sec. 5402. Establishment of all-payer health care fraud and abuse control account

All criminal fines, penalties, and civil monetary penalties imposed for violations of fraud and abuse provisions would be deposited in an account, which would supplement funding for the fraud and abuse control program. 20 percent of account funds would be used for provider and consumer education, including advisory opinions to facilitate compliance with the anti-fraud and abuse provisions of this act.

Sec. 5403. Use of fraud by inspector general

The Inspector General is authorized to receive and retain court awarded restitution for the costs of its investigations.

Sec. 5404. Reward for information leading to prosecution and conviction

The HHS Secretary and the Attorney General are authorized in special circumstances to jointly offer a reward of up to \$10,000 for information related to the possible prosecution of a health care offense.

Part 2. Civil penalties and rights of action

Sec. 5411. Civil monetary penalties

Similar to existing authority under the Social Security Act, the HHS Secretary would be authorized to impose civil monetary penalties up to \$10,000 for false or violative claims and \$15,000 for giving misleading information in the decision to discharge a patient. The Secretary would also be authorized to exclude individuals from participation from all health plans.

Recovered funds would be returned to health plans, with the remainder going to the fraud and abuse control account (see section 5403). The section also provides for appeal proceedings.

Sec. 5412. Permitting parties to bring action on their own behalf

A private right of action in U.S. District Court would be available to health plans or large group sponsors which suffer harm or monetary loss related to a health care offense of at least \$10,000 and inform the Attorney General, who then decides not to pursue action. Awards could include treble damages, attorney's fees and equitable relief; 20 percent of any award in excess of damages goes to the fraud and abuse control account (see section 5403). Clarifies that no other right of action is limited by this provision, and clarifies that the section does not give Federal court jurisdiction over any State court claim.

Sec. 5413. Exclusion from program participation

The HHS Secretary would be required to exclude individuals or entities convicted after the effective date of this act of health care felonies, patient abuse, and substance abuse felonies, from participation in health plans for no less than two years, unless such exclusion would significantly harm public health. The Secretary would continue to have authority to order different periods of exclusion for other health care convictions. The section also provides for notice of exclusion and hearings.

Part 3. Amendments to criminal law

Sec. 5421. health care fraud

Creates a broad new provision for criminal code health care fraud, with up to 10 years imprisonment and fines for defrauding a health alliance, plan or other person. Provides for life or other imprisonment for those convicted of serious bodily harm.

Sec. 5422. Theft or embezzlement

Provides for up to 10 years imprisonment and fines for those convicted of theft or embezzlement against health alliances or plans.

Sec. 5423. False statements

Provides for up to 5 years imprisonment and fines for those convicted of making false statements relating to matters involving a health alliance or health plan.

Sec. 5424. Bribery and graft

Provides for up to 15 years imprisonment and fines for those convicted of bribery of a health care official to influence the official's actions, and for health care officials convicted of accepting such a bribe.

Sec. 5425. Injunctive relief relating to health care offenses

provides injunctive relief with respect to an anticipated health care offense.

Sec. 5426. Grand jury disclosure

Authorizes persons privy to grand jury information involving health care fraud or abuse to disclose it to the government for use in civil proceedings or forfeitures.

Sec. 5427. Forfeitures for violations of fraud statutes

Provides, upon conviction of a criminal health care offense, for the forfeiture of property constituting or traceable to the gross proceeds of such violation.

*Part 4. Amendment to False Claims Act**Sec. 5431. Amendments to Civil False Claims Act*

Amends Civil False Claims Act which makes it applicable to payments to health plans.

*Part 5. Effective date**Sec. 5441. Effective date*

Provides for effective date of January 1, 1995.

SUBTITLE F

Sec. 5501. Repeal of exemption for health insurance

Amends the McCarran-Ferguson Act to repeal the exemption for health insurance.

*Title VI. Premium Caps; Premium-Based Financing; and Plan Payments**Sec. 6000. General definitions*

This section provides definitions for this title, as follows:

Filed Per Capita Community Bid.—The bid filed with a State by health plans for coverage of the comprehensive benefits package.

Accepted Per Capita Cooperative Bid.—The premium rate agreed to by a cooperative and a health plan for coverage of the comprehensive benefits package, taking into account any discount negotiated under section 1311(b)(2).

Final Community Rate.—The filed per capita cooperative bid, taking into account any voluntary reduction in the bid made under section 6004(e).

Final Cooperative Rate.—The accepted per capita cooperative bid, taking into account any voluntary reduction in the bid made by a noncomplying plan under section 6004(e).

Weighted Average Accepted Bid.—For a health care coverage area, the average across all plans of—

The filed per capita community bid for each health plan offered in a health care coverage area weighted to reflect the relative enrollment (net of any enrollment through a cooperative) among such plans; and

The accepted per capita cooperative bid for each health plan offered in a health care coverage area weighted to reflect the relative enrollment through a cooperative among such plans.

Weighted Average Discount Rate.—For a health care coverage area, the lesser of—

The per capita premium target for the health care coverage area (as defined in section 6003) for the year; or,

The average across all plans of the lesser of (i) the final community rate or, (ii) the final cooperative rate, (applicable only for plans offered through a cooperative) for each health plan, weighted to reflect the total enrollment among such plans.

Weighted Average Premium.—For a class of enrollment and with respect to a health care coverage area for the year, the product of the weighted average discount rate, the uniform per capita conversion factor (established under section 6211) for the area, and the premium class factor established by the Board for that class under section 1631.

SUBTITLE A. PREMIUM CAPS

Subtitle A describes computation and enforcement of premium caps for health care coverage areas and for large group purchasers.

Part 1. Health expenditures of health care coverage areas

Part 1 relates to premium caps for health care coverage areas.

Subpart A. Computation of targets and accepted bids

Subpart A describes the computation of per capita premium targets, and the process by which plan bids are submitted and reviewed.

Sec. 6001. Computation of health care coverage area inflation factors

The Board computes and publishes each year, not later than March 1, the area inflation factor for each health care coverage area for the following year. The health care coverage area inflation factor is the general health care inflation factor, adjusted to take into account changes in the demographic and socioeconomic characteristics of the health care coverage area population. The health care coverage area inflation factor is also increased for the year 2001 to reflect the actuarial value of the increase in the comprehensive benefits package, not to exceed with respect to mental illness and abuse services the expenditures that States and subdivisions of States would have made for such services in 2001 if that act had not been enacted.

The general health care inflation factor is the increase in the CPI plus: 1.5 percent for 1996; 1.0 percent for 1997; 0.5 percent for 1998; and 0.0 percent for 1999 and 2000.

In 1999 the Board submits to Congress recommendations regarding the general inflation factor for 2001 and beyond. In the event Congress fails to enact a law specifying the factor, the default general health care inflation factor is the combination of the percentage change in CPI and the percentage change in the real Gross Domestic Product per capita.

The Board must develop a method for adjusting health care coverage area inflation factors for the following purposes:

To reflect material changes in the demographic characteristics of community-rate eligible individuals of any large group purchasers terminating their status as large group purchaser, and entering into contract with community-rated health plans.

To reflect changes in the demographic characteristics and health status of community-rate eligible individuals in a health care coverage area. Any such adjustments may not result in a change in the overall weighted average of the health care coverage area inflation factors across all health care coverage areas.

The Board must consult with States and purchasing cooperatives before establishing the health care coverage area inflation factors each year.

Sec. 6002. Board determination of national per capita baseline premium target.

By January 1, 1995, the Board must determine a national per capita baseline premium target, which is the national average per capita current coverage health expenditures, inflated to 1995.

The national average per capita current coverage health expenditures is total covered current health care expenditures, divided by the estimated population of community-rate eligible individuals (not including AFDC or SSI recipients).

Current health care expenditures are total payments for the comprehensive benefits package in 1993, decreased by the proportion of such payment attributable to Medicare, AFDC or SSI beneficiaries, workers' compensation or automobile insurance, and other payments which will not be made by community-rated health plans for coverage of the comprehensive benefits package.

This amount is increased to include expected increases in utilization by those currently uninsured or underinsured (at average rates of provider payment), and uncompensated care is removed. It is also increased to reflect the estimated percentage for administrative costs of health plans, alliances, and state premium taxes (not to exceed 15 percent).

The total payments are decreased by the amount that will be subject to cost-sharing (under a high cost sharing plan), and the decrease in utilization from such cost sharing.

The Board shall update the amount determined for 1994 and 1995 based on the increase in private sector health care spending.

Sec. 6003. Determination of area per capita premium targets

By January 1, 1995, the Board must determine, for each health care coverage area for 1996, a health care coverage area per capita premium target. The health care coverage area per capita premium target is the national per capita baseline premium target, updated

by the health care coverage area inflation factor, and adjusted by the area's adjustment factor.

The Board must establish an adjustment factor for each health care coverage area, taking into account the difference between the national average of the factors used in determining the national per capita baseline premium target and the amount of those factors for the health care coverage area, including variations in health care expenditures, in rates of uninsurance and underinsurance, and in the proportion of expenditures for academic health centers.

The type of information considered by the Board may include information on variations in premiums across States and across health care areas: in per capita health spending by State; in per capita spending under the Medicare program; and on rating factors commonly used by actuaries.

The adjustment factors must be determined in a neutral manner, meaning that the weighted average of the health care coverage area per capita premium targets must equal the national per capita baseline premium target.

If a state is not a participating State at the time of computation by the Board, the entire state is treated as one coverage area. If a State changes coverage area boundaries, the Board provides for a method for computing a new health care coverage area per capita premium target for each coverage area in a neutral manner.

For each succeeding year, by March 1, the Board shall determine a health care coverage area per capita premium target, which is the health care coverage area per capita premium target from the previous year updated by the health care coverage area inflation factor.

If actual weighted average accepted bid for a coverage area for a year (based on actual enrollment in the first month of the year) exceeds the health care coverage area per capita premium target, then the health care coverage area per capita premium target is adjusted downward in each of the following 2 years to recoup the overage (based on a formula described in this section).

Sec. 6004. Initial rate filing and bid negotiation process

By July 1 of the first year and by August 1 of each succeeding year, each health plan that would like to participate as a community-rated health plan must file a premium bid with the State. Each bidder must accept the condition that the premium may be reduced under section 6011.

Each health plan filing a premium bid with the State must also submit a bid to the cooperative(s) serving the health care coverage area. This bid cannot exceed the bid filed with the State. After a period for negotiation with the cooperative(s), the final bid submitted by a health plan is considered the plan's accepted cooperative bid.

Each State must report to the Board by September 1 the final bids for plans in the health care coverage areas, with information on the likely distribution of enrollment (for the first year), and actual existing enrollment (in future years). Using this information, the Board determines the weighted average accepted bid and weighted average discount rates for each health care coverage area.

By October 1 the Board must notify the State if the weighted average accepted bid for the health care coverage area is greater than the health care coverage area per capita premium target. The Board must also notify the State and each noncomplying plan of any plan payment reductions computed under section 6011. Noncomplying health plans are given the opportunity to voluntarily reduce their bids consistent with any plan payment reductions.

Sec. 6005. State financial incentives.

Any participating state may elect to assume responsibility for containment of health care expenditures. For a State that elects to assume responsibility, if the statewide weighted average of the weighted average discount rates is less than the statewide weighted average of the per capita premium targets, then one-half of the percentage reduction in health care spending multiplied by Federal payments to states for discounts is made available to the State by reducing the State's maintenance of effort payment for the following year.

A participating State may regulate provider rates charged to private payers. such regulation may not cause an experience-rated health plan to be charged rates different from those charged other health plans or otherwise discriminate against experience-rated health plans.

Sec. 6006. Recommendations to eliminate regional variations in area targets due to variation in practice patterns; congressional consideration

An advisory commission is established that will examine and report to the Board on methods of reducing or eliminating variation in area premium targets due to variations in practice patterns and methods of reducing the variation in State payments for AFDC and SSI recipients and for maintenance of effort under title IX, subtitle A.

By October 1, 1996, the Board must submit to Congress separate detailed recommendations based on each of the commissions reports. Each of the Board's recommendations apply unless a joint resolution disapproving the recommendation is enacted within 60 days.

Sec. 6007. Reference to limitation on administrative and judicial review of certain determinations

Limitations on administrative and judicial review of certain determinations under this part are described in section 5232.

Sec. 6008. Application of marketing and cooperative fees

Marketing and cooperative fees are not included in the premium of a plan in determining plan and area compliance with premium targets for purposes of determining eligibility for discounts.

Subpart B. Plan and provider payment reductions to maintain expenditures within targets

Subpart B describes the calculation of plan and provider payment reductions for noncomplying plans in areas where the weighted average accepted bid exceeds the per capita premium target.

Sec. 6011. Plan payment reduction

In order to assure that payments to community-rated health plans are consistent with the health care coverage area per capita premium target for the area, each noncomplying plan is subject to a reduction in plan payment by the amount equal to the plan payment reduction.

A community-rated health plan is a "noncomplying plan" if the plan is offered in a noncomplying health care coverage area and the plan's applicable premium rate for the year exceeds the plan's maximum complying bid. A health care coverage area is a "non-complying area" if the area's weighted average accepted bid (computed under section 6004(c)) exceeds the health care coverage area's per capita premium target.

In each year, the maximum complying bid for each health plan in a noncomplying health care coverage area is the health care coverage area per capita premium target for the area.

For new plans, the maximum complying bid is also the health care coverage area per capita premium target. The Board or a state may modify this rule in order to prevent abusive premium practices by entities previously offering plans, to encourage the availability of all types of plans in the State, or to permit the establishment of new plans.

Plan payment reductions for noncomplying plans are calculated by multiplying a plan's excess bid amount by the area-wide reduction percentage. The excess bid amount for a noncomplying plan is the amount by which the plan's accepted bid (before any voluntary reductions) exceeds the plan's maximum complying bid.

The area-wide reduction percentage is calculated so that plan payment reductions are sufficient to bring the weighted average of bids (after plan payment reductions) down to the health care coverage area per capita premium target.

The area-wide reduction percentage is equal to the difference between the weighted average accepted bid for the coverage area and the area's per capita target, divided by the sum (across all non-complying plans) of the "plan proportion of area excess bid amount." The "plan proportion of area excess bid amount" for a plan is the excess bid amount for the plan, multiplied by the proportion of the community-rate eligible individuals enrolled in that plan.

Plans that have accepted cooperative bids that are different from the final community rate are treated as separate plans with separate enrollment for each premium rate.

Sec. 6012. Provider payment reduction

Each community-rated health plan, as part of its contract or agreement with any participating provider, must: Include a provision that provides that payments to the provider are reduced by the applicable network reduction percentage if the plan is a non-complying plan for a year. Plans can not include any provision which the State determines is intended to nullify the effect of such reductions.

The applicable network reduction percentage for a noncomplying plan is equal to the plan payment reduction amount for the plan divided by the final accepted bid for the plan, and increased by the

Board to take into account any estimated increase in volume of services that may reasonably be anticipated as a consequence of applying a reduction in payment.

For providers that are not participating providers, a noncomplying plan must reduce payments by the applicable nonnetwork reduction percentage.

The applicable nonnetwork reduction percentage for a plan is equal to the plan payment reduction amount for the plan divided by the final accepted bid for the plan, and increased by the Board to take into account any estimated increase in volume of services that may reasonably be anticipated as a consequence of applying a reduction in payment.

Restrictions on balance billing and computation of any cost sharing are based on the reduced payments by noncomplying plans, as determined under this section.

Part 2. Health expenditures of large group purchasers

Sec. 6021. Calculation of premium equivalents

The Board must develop a methodology for calculating an annual per capita expenditure equivalent for amounts paid for coverage for the comprehensive benefit package within a large group purchaser. A large group purchaser will be able to petition the Secretary of Labor for an adjustment to compensate for material changes in the demographic characteristics of the experience-rate eligible individuals receiving coverage through the sponsor.

In the year 2001 and each subsequent year, each large group purchaser must report to the Secretary of Labor the average of the annual per capita expenditure equivalent for the previous 3-year period.

Sec. 6022. Sanctions for large group purchasers for excess increase in expenditures

If a large group purchaser that is a large employer has two "excess years" in a 3-year-period, then the Secretary of Labor shall take action and the experience-rated employers of the large group purchaser are required to become community-rated employers.

For other large group purchasers whose election is terminated under this section, employer premium payments are subject to adjustment under section 6124.

Part 3. Treatment of single-payer States

Sec. 6031. Special rules for single-payer States

The Board must compute a statewide per capita premium target for each year in the same manner as a health care coverage area per capita premium target is determined under section 6003.

Part 4. Transition provisions

Sec. 6041. Monitoring prices and expenditures

The Secretary must establish a program to monitor prices and expenditures in the health care system report periodically to the President.

Sec. 6042. Health care utilization research program

To assist health plans in determining the appropriate cost of services to populations not previously covered by private health insurance, the Secretary shall conduct research on the characteristics and health care utilization of such populations.

SUBTITLE B. PREMIUM-RELATED FINANCING

Subtitle B describes premium payment requirements and discounts for families and employers.

Part 1. Family premium payments

Subpart A. Family share

Subpart A describes the family share of premiums.

Sec. 6101. Family share of premium

Each family enrolled in a community-rated or experience-rated health plan is responsible for paying the family share of premium. The family share of premium may be paid by an employer or other person on behalf of the family.

Two methods are used to calculate the family share of premium, one for families enrolled in community-rated health plans and one for families enrolled in experience-rated health plans.

For families enrolled in community rated health plans, the family share of premium is equal to "base amounts" minus "credits and discounts." The family share of premium cannot be less than zero. Base amounts are the total premium for the applicable family class of enrollment increased by the appropriate portion of the family collection shortfall add-on. Credits and discounts are the sum of:

- (1) The family credit, equal to 80 percent of the weighted average premium;
- (2) Any income-related discount provided under section 6104(a)(1);
- (3) Any excess premium credit provided under section 6105; and
- (4) Any large group purchaser opt-in credit provided under section 6106.

AFDC and SSI recipients also receive a credit for the family collection shortfall add-on amount.

For families enrolled in experience-rated health plans, the family share of premium is equal to the premium for the health plan in which the family is enrolled minus "credits and discounts." The family share of premium cannot be less than zero.

Credits and discounts are the family credit under section 6103(b) (equal to the minimum employer premium payment (under section 6131) and any income-related discount under section 6104(a)(2).

Sec. 6102. Amount of premium

The amount of the premium charged by a community-rated health plan is specified in this section. The amount of the premium charged by an experience-rated plan is specified in section 1384.

The amount of the premium charged by a community-rated health plan in a health care coverage area varies only by the class of enrollment, and is equal to the product of:

(1) The final community rate or cooperative rate (depending on how the family enrolls) for the plan, which is a per capita amount.

(2) The uniform per capita conversion factor for the health care coverage area, which converts the final per capita rate to a premium for the "individual" class of enrollment.

(3) The premium class factor for a given class of enrollment (established by the Board under section 1531). The premium class factors, which are uniform across all health care coverage areas, convert a premium for the individual class of enrollment to the premiums for other classes of enrollment.

Special rules apply in the cases of divided families (as described in section 1012).

Sec. 6103. Family credit

Each family enrolled in a community-rated health plan receives a credit equal to 80 percent of the weighted average premium (as defined in section 6000(c)) for health plans offered in the health care coverage area, for a given class of enrollment.

Each family enrolled in an experience-rated health plan receives a credit equal to the minimum employer premium payment for the family (under section 6131).

Sec. 6104. Premium discount based on income

Two methods are used to calculate premium discounts, one for families enrolled in community-rated health plans and one for families enrolled in experience-rated health plans.

Each family enrolled in a community-rated health plan is entitled to a premium discount, depending on family income and status as an AFDC or SSI recipient. The amount of premium discount for a family is equal to 20 percent of the weighted average premium for community rated health plans minus the family obligation amount (described below) and any employer payment toward the family share of premium. A family's premium discount may not be less than zero.

If a state determines that a family eligible for a discount under this section is unable to enroll in an at-or-below-average-cost plan that serves the area in which the family resides, the amount of the premium discount is increased by the minimum amount necessary to permit the family to enroll in a community-rated health plan without paying an additional amount. An "at-or-below-average-cost plan" is a plan whose premium does not exceed, for a given class of enrollment, the weighted average premium for the health care coverage area.

For AFDC and SSI families and for families with income below a specified income threshold amount, the family obligation amount is zero. The income threshold amount is \$1,000, inflated by the CPI for years following 1994.

For other families with income below 150 percent of the poverty level, the family obligation amount is the sum of:

(1) The initial marginal rate (for the applicable class of enrollment) multiplied by income between the income threshold amount and the poverty level (for the applicable class of family); and

(2) The final marginal rate (for the applicable class of enrollment) multiplied by income between the poverty level and 150 percent of the poverty level (for the applicable class of family). The initial and final marginal rates are calculated according to formulas specified in this section.

For families with income above 150 percent of poverty, the family obligation amount is capped at 3.9 percent of income.

Families enrolled in experience-rated health plans are entitled to a premium discount if the employee through which the family is enrolled is a low-wage employee. A low-wage employee must be employed on a full-time basis and earn wages less than \$15,000 a year, indexed according to rules specified in this section.

For such low-wage employees, the premium discount is the amount (if any) by which 95 percent of the premium for the least expensive low or combination cost sharing plan offered to the employee (for the applicable class of enrollment) exceeds the minimum employer premium payment for the family.

Sec. 6105. Excess premium credit

If enforcement of premium caps results in plan payment reductions made for one or more health plans offered in a health care coverage area (under section 6021), a credit to pass on the benefit of these reductions is provided to each family enrolled in health plan in the coverage area.

The credit is first calculated as a per capita amount—the per capita excess premium amount—which is equal to the amount (if any) by which the health care coverage area's weighted average accepted bid exceeds its per capita premium target.

This per capita amount is then converted into excess premium credits for each class of enrollment based on the same method that is used to convert the weighted average discount rate to the weighted average premium for that class of enrollment.

The excess premium credit is adjusted for under or over estimates of the credit in a previous year.

Sec. 6106. Large group purchaser opt-in credit

If a payment adjustment is owed as a result of the termination of an election to be a large group purchaser, then each family is provided with a credit based on the payment adjustments.

The credit is first calculated as a per capita amount—the per capita large group purchaser opt-in amount—based on 20 percent of the total of payment adjustments and the estimated number of community-rate eligible individuals in the health care coverage area.

This per capita credit is then converted into large-group purchaser opt-in credits for each class of enrollment based on the same method that is used to convert the weighted average discount rate to the weighted average premium for that class of enrollment.

Sec. 6107. Family Collection shortfall add-on

A family collection shortfall add-on is calculated to raise funds to pay for premiums owed to community-rated health plans in a health care coverage area but not collected. The add-on is first calculated as a per capita amount—based on an estimate of the total

amount owed to plans but which they are unable to collect and the total number of community-rate eligible individuals in the area.

The Board shall develop a method for apportioning the collection shortfall amount across payers on the basis of a blending of the per-capita shortfall amount with the shortfall generated by enrollees of each plan.

Sec. 6108. No loss of coverage

In no case shall a failure to pay amounts owed under this act result in an individual's or families loss of coverage.

Subpart B. Repayment of family credit by certain families

Subpart B describes repayment of the family credit for certain families (in particular, those who do not work full-time for the entire year and have sufficient income).

Sec. 6110. Repayment of family credit by certain families

Each family which is provided a family credit (under section 6103) is liable for repayment of the family credit. Repayment is based on the base employment monthly premium for the family's class of enrollment.

Any payments made by a self-employed member a family as an employer (under section 6126) reduce a family's liability for repayment of the family credit (but not below zero).

Sec. 6111. No liability for families employed full-time; reduction in liability for part-time employment

Employment by any family member who is a qualifying employee reduces the family's liability for repayment of the family credit.

For a family enrolled in a community-rated health plan for the entire year, full-time employment during a month reduces the family's liability by one-twelfth. Therefore, full-time employment for the entire year means the family has no repayment obligation.

Part-time employment during a month reduces the liability in proportion to the amount of time worked (as measured by the employment ratio under section 1901(b)(2)(B)).

For a family enrolled in a community-rated health plan for only part of the year, the one-twelfth fraction specified above is instead equal to one divided by the number of months the family was enrolled in a community-rated health plan.

The liability is reduced (but not below zero) by the total of all qualified employment by members of a family, including where multiple jobs are held by one family member or where both spouses work during the year. A family with a total of twelve months of qualified employment has no repayment liability.

Sec. 6112. Limitation of liability based on income

The liability for repayment of the family credit (reduced through employment and self-employment, as described in sections 6111 and 6112) is capped based on the family's wage-adjusted income.

Wage-adjusted income is equal to family adjusted income (as defined in section 1372(d)(1)), reduced by wages up to \$5,000 per month; net earnings from self employment; and unemployment

compensation (included in income under section 85 of the Internal Revenue Code of 1986).

AFDC and SSI families and families with wage-adjusted income below a specified income threshold amount have no repayment obligation. The income threshold amount is \$1,000, inflated by the CPI for years following 1994. Other families with wage-adjusted income less than 300 percent of the applicable poverty level are eligible for a discount for repayment of the alliance credit. Their obligation is capped at the following level:

(1) The initial marginal rate (for the applicable class of enrollment) multiplied by income between the income threshold amount and the poverty level (for the applicable class of family); plus

(2) The final marginal rate (for the applicable class of enrollment) multiplied by income between the poverty level and 200 percent of the poverty level (for the applicable class of family).

The initial and final marginal rates are calculated according to formulas specified in this section.

Sec. 6113. Payment by non-qualifying employees

For families with one or more employees employed by exempt firms and none employed by a community-rated employer, the family is liable for the family share of the premium (including any applicable discounts under section 6113), and the family credit repayment amount (including any reduction under section 6113).

A family's liability for the sum of the family share and the employer share is limited to four percent of family adjusted income for families with incomes less than 150 percent of poverty; to 4.5 percent of income for families with incomes less than 175 percent of poverty, but more than 150 percent of poverty; to 5 percent of income for families with incomes of less than 225 percent of poverty, but more than 175 percent of poverty; and to six percent of income for families with incomes more than 225 percent of poverty, but less than 400 percent of poverty.

Sec. 6114. Special treatment of certain retirees and qualified spouses and children

An individual who is an eligible retiree, or a qualified spouse or child of an eligible retiree, is considered to be a full-time employee for the purpose of repayment of the family credit, and therefore has no repayment obligation.

An eligible retiree is someone who meets all of the following conditions: (1) is between age 55 and 65; (2) is not employed on a full-time basis; (3) has met the work requirements to be eligible for Medicare part A hospital insurance benefits or has worked forty quarters with a State or local government; and (4) is not a Medicare-eligible individual.

Sec. 6115. Special treatment of certain Medicare beneficiaries

Medicare eligible individuals who are qualified employees or spouses of qualified employees (as determined under section 1012(a)) are considered to be full-time employees for the purposes of repayment of the alliance credit, and therefore have no repayment obligation.

Part 2. Employer premium payments

Subpart A. Small employers exempt from coverage obligations

Sec. 6116. Exemption from coverage obligations

A small employer as defined in section 6117 is exempt from the required premium payments.

Sec. 6117. Small employer defined

A small employer is one with no more than 10 full-time equivalent employees and average wages of less than \$24,000 a year per full time equivalent employee.

Sec. 6118. Election

A small employer may elect to be treated as a community-rated employer.

Sec. 6119. Treatment of small employers

If a small employer elects to be treated as a community-rated employer, they are eligible for the same subsidies under section 6123 as employers with fewer than 15 full-time equivalent employees.

Sec. 6120. Nonelecting small employer

A nonelecting small employer is one that does not elect to be treated as a community-rated employer. Instead of paying premiums for their employees, these employers contribute an assessment of payroll equal to 1 percent for employers with five or fewer full-time equivalent employees and 2 percent for employers with six to ten full-time equivalent employees.

Subpart B. Community-rated employers

Sec. 6121. Employer premium payment required

Requires each community-rated employer to pay a premium for each qualifying employee employed in the month. Experience-rated employers must pay premiums as community-rated employers for their part-time, seasonal, and other employees who are not experience-rate eligible employees.

For each qualifying employee, the employer's payment is the product of the base employer monthly premium for the class of family enrollment (as determined under section 6122) chosen by the employee and the employee's full-time employment ratio.

Default payment rules are established if an employer does not know the class of family enrollment or the residence of a qualifying employee. If the class of family enrollment is not known, the employer's premium is based on the two parent family class of enrollment. If the employee's residence is not known, the employee is deemed to reside in the health care coverage area in which the employee principally is employed by the employer.

Employer payments for the first month after implementation in a State are made on the first of the month and are based on an estimate of the amount that will be owed for the month. An adjustment is made to the payment in the following month to reflect the difference between the estimated payment and the actual

amount owed (based on employment and hours worked in the month).

In the case of families whose coverage is divided under section 1012, the employer's premium obligation is calculated as if the family was not divided the premium payments will be divided on a proportional basis to the health plans chosen by the respective family members.

(c) Describes the how the section applies during the transition (1996-98) for employers with employees in more than one State. Generally, the requirements of the subpart apply to an employer only with respect to qualifying employees residing in participating States. However, in determining whether an employer is a small employer, all of the employees of the employer (whether or not they reside in participating States) are counted.

Sec. 6112. Computation of base employment monthly premium

Each State calculates a base employment monthly premium for each class of family enrollment.

For the individual class of enrollment, the base employment monthly premium is equal to one-twelfth of 80 percent of the credit-adjusted weighted average premium for the individual class of enrollment. The credit-adjusted weighted average premium is the lighted average premium for a class of enrollment, reduced by the large group purchaser opt-in credit.

For the couple-only class of enrollment, the base employment monthly premium is equal to one-twelfth of 80 percent of the total premiums for couple-only enrollments, divided by the number of covered families and extra workers in the alliance in that class of enrollment.

Total premiums are calculated by multiplying the credit-adjusted weighted average premium for the couple-only class of enrollment and the total number of covered couple-only families in the health care coverage area.

The term covered family does not include SSI or AFDC families, families in which one spouse is a Medicare eligible individual, or families that are enrolled in health plans that are not community-rated health plans.

Extra workers are counted where the number of premium payments in a family exceeds one. Each family counts as at least one premium payment, but may count as more than one premium payment if both spouses are qualifying employees. In a family where both spouses are qualifying employees, the number of premium payments is the sum across both spouses of the number of full-time equivalent employees each spouse is counted as. No spouse can be counted as more than one full-time equivalent employee.

The base employment monthly premium is the same for the single parent and dual parent classes of enrollment. It is equal to one-twelfth of 80% of the combined total premiums for both classes of enrollments, divided by the combined number of covered families and extra workers in the health care coverage area in those classes of enrollment. Total premiums and extra workers are calculated in the same manner as described above for the couple-only class of enrollment.

Sec. 6123. Premium discount for certain employers

A discount is provided to community rated employer equal to the amount by which their required premium payments for an employee exceed the limiting percentage of the employee's wages.

In general, the premium payment required for an employer for an employee for any year is capped at the limiting percentage of the employer's wages for that year. The cap does not apply with respect to the employer collection shortfall add-on. Nor does it apply to the Federal Government or to a "dual-choice" employer electing to become a large group purchaser.

Subsections (b) and (c) define the limiting percentages for all employers. In general, the limiting percentage is 12 percent of each qualifying employee's annual wages. For employers with fewer than 75 full-time equivalent employees and average annual wages of less than \$24,000, the limiting percentage is the applicable percentage from the following table:

MEDIUM-SIZED EMPLOYER DISCOUNTS

Firm size	Average pay—					
	<12K	<15K	<18K	<21K	<24K	<24K+
<15	4.2	5.5	6.8	8.1	9.4	12
16-24	5.5	6.8	8.1	9.4	10.7	12
25-49	6.8	8.1	9.4	10.7	12	12
50-74	8.1	9.4	10.7	12	12	12

Self-employed individuals who are partners in a partnership, 2-percent shareholders in an S corporation (as defined in section 1372 of the Internal Revenue Code of 1986), or who otherwise carry on a trade or business as a sole proprietorship are deemed to be employees of the partnership, S corporation, or proprietorship and any net earnings of the individual from self employment attributable to the partnership, S corporation, or sole proprietorship are deemed to be wages from the partnership, S corporation, or proprietorship.

Employers claiming a discount under this section must provide notice when premium payments are made. Employers claiming discounts must make information available to permit audits the average number of full-time equivalent employees, average annual wages, and the total wages paid by the employer for qualifying employees.

Sec. 6124. Payment adjustment for certain large employers

This section provides for an adjustment to premium payments by large employers whose election to be a large group purchaser has been terminated. The adjustment is equal to the excess risk amount represented by the employees of the employer as determined by the Board.

Sec. 6125. Employer collection shortfall add-on

The employer premium collection shortfall add-on is added to the premiums payable by employers to raise funds to pay for premium amounts owed to community-rated health plans but not collected. As with the family collection shortfall add-on, the Board will de-

velop a method for distributing the total shortfall amount across all community-rated employers.

Sec. 6126. Application to self-employed individuals

Provides that a self-employed individual is considered to be an employer of himself or herself and to pay wages to himself or herself equal to the amount of net earnings from self-employment (as defined in section 1901(c)(1)).

Self-employed individuals are required to pay premiums under this subpart as employers (subject to the exemption and discounts available to small employers) from the amount of net earnings from self-employment. The amount of employer premium required in a year is reduced (but not below zero) by the amount of any premium contributions required from a community-rated employer (without regard to any discounts under section) plus any premium contributions required from large group purchasers.

For individuals who have a substantial amount of wage-adjusted income and are substantial owners and who are employees of closely held businesses, the amount of any reduction attributable to the individual's employment by that business will be reduced (in accordance with rules prescribed by the Board) to prevent individual from avoiding payment of the full amount owed through fraudulent or secondary employment arrangements.

A business is considered closely held under this section if the employer meets the requirements of section 542(a)(2) of the Internal Revenue Code of 1986 (or any similar requirements as appropriate in the case of a partnership or other entity).

Subpart C. Large group purchasers

Sec. 6131. Large employer premium payment required

Each experience-rated employer of a large group purchaser is required to make a premium payment on behalf of their employees. In general, the employer premium for a month for a family is 80 percent of the weighted average monthly premium of the experience-rated health plans offered by the large group purchaser. Special rules apply to estimation of premiums of self-insured plans.

For low-wage employees entitled to a premium discount under section 6104, the employer premium payment for a month is increased by the amount of the discount provided under that section.

Sec. 6132. Assistance for low-wage families

Each large group purchaser shall make an additional contribution toward the enrollment in health plans of the purchaser by certain low-wage families in accordance with section 6131(b)(2). An experience-rated health plan shall provide reductions in cost sharing to levels specified in section 1281 to experience-rated individuals who would be eligible for such reductions were they enrolled in a community-rated plan.

Sec. 6133. Excess increase in premium equivalent

If the Secretary of Labor finds that a large group purchaser (other than a large employer) is in violation of the requirements of section 6022 (relating to prohibition against excess increase in pre-

mum expenditures), the Secretary shall terminate the sponsorship in accordance with such section.

Sec. 6134. Ineligibility for premium assistance

An employee who is a citizen or resident of the United States who is performing services outside the United States for an American employer and who is insured under this act shall be ineligible for premium discounts or other subsidies under this title. Nor will their employer be eligible. Such individuals shall also be required to pay an administrative surcharge determined by the Office of Personnel Management.

Sec. 6135. Cost control

Each large group purchaser shall control covered expenditures in a manner that meets the requirements of part 2 of subtitle A of this title.

Sec. 6136. Coordination of payments

In the case of a married couple in which one spouse is a qualifying employee of a community-rated plan or another large group purchaser, the large group purchaser shall make such payments as are required under this Act to the plan in which the family is enrolled pursuant to rules issued by the Secretary of Labor.

Subtitle C. Payments to health plans and miscellaneous provisions

Sec. 6200. Assistance to plans

States shall be responsible for assisting health plans and cooperatives in the collection of premium payments. A State may establish administrative systems to facilitate the collection of premiums from employers and families and the distribution of such premiums to health plans, consistent with rules promulgated by the Board.

Sec. 6201. Computation of blended per capita payment amount

The blended per capita payment amount is a blend of the final accepted bid of the plan, the AFDC component, and the SSI component.

Sec. 6202. Computation of plan bid, AFDC, and SSI proportions

The plan bid proportion is one minus the sum of the AFDC and SSI proportions. The AFDC and SSI proportions reflect the percentage of AFDC and SSI recipients in the health care coverage area.

Sec. 6203. Payment to community-rated health plans

For purposes of making payments to plans under this section, a State shall compute a blended plan per capita amount for each community-rated health plan.

A State shall provide for payment to each plan an amount equal to the net blended rate adjusted (consistent with subsection (c)) to

take into account the relative actuarial risk associated with the coverage with respect to the individuals enrolled.

The net blended rate is the blended plan per capita payment amount (determined under section 6201(a)), reduced by the administrative allowance percentage, computed under section 1262 (plus 1.5 percentage points); and any plan payment reduction imposed under section 6011 for the plan for the year.

A State shall use the reinsurance and risk adjustment methodology developed under section 1641 in making payments to health plans under this section.

Sec. 6204. Calculation and publication of general family share and general employer premium amounts

Each State shall compute and publish the general family share of the premiums of each plan in each health care coverage area. The State shall also calculate and publish: the amount of any family collection shortfall for each plan; the premium discount for health promotion programs; the family credit amount for each class of family enrollment; the amount of any excess premium credit provided under section 6105; and the amount of any large group purchaser opt-in credit provided under section 6106.

Each State shall also compute and publish the following components of the general employer share for each health care coverage area: the base employer monthly premium for each class of enrollment; the premium discount for each level of worksite health promotion programs; and the employer collection shortfall add-on.

Each State shall provide for the reconciliation of family payments in cases where the State determines that there has been an overpayment or underpayment by or on the behalf of such families in accordance with rules promulgated by the Board. In carrying out these duties, a State shall provide notice of amounts owed or due to such families, distribute information on the availability of premium discounts and reductions to such families and include income reconciliation forms for families that are provided with premium discounts. In addition, if a State determines under section 1213 that a family has paid any family share required under section 6101 and is not required to repay any amount under section 6111 for a year, the State shall provide notice of such determination to the family.

The State in which the community-rated plan in which a family is enrolled in December of each year is responsible for the collection of any amounts owed by the family under this subpart, without regard to whether the family resided in the State during the entire year in accordance with rules promulgated by the Board.

Sec. 6205. Adjustment of payments to health plans

States shall develop payment adjustment mechanisms and collect such information as may be necessary for ensuring that payments to health plans are appropriate and sufficient. Such mechanisms shall include: methods for risk adjustment and reinsurance (in accordance with section 1641 and 1642); the payment of premium discounts (in accordance with subtitle B of title VI); per capita payment adjustments to reflect each area's share of AFDC and SSI beneficiaries (in accordance with subtitle C of title VI), and; other

adjustments necessary to reconcile the amounts collected by plans with the amounts plans are owed.

Sec. 6206. Employer payment requirement

Each employer shall provide for payments required under section 6121 or 6131 in accordance with the applicable provisions of this act. In the case of an employer with respect to employees who reside in a single-payer State, the responsibilities of such employer under such system shall supersede the obligations of the employer under subsection (a), except as the Board may provide.

In the case of an employer participating in a multiemployer plan, which plan elects to serve as a community-rated employer on behalf of its participating employers, the employer's payment obligation under section 6121 shall be deemed satisfied if the employer pays to the multiemployer plan at least the premium payment amount specified in section 6121(b) and the plan has assumed legal obligations of such an employer under such section.

Sec. 6207. Requirement for employer payment and reconciliation reporting

Each employer shall provide to each of their employees information on their number of months of full-time equivalent employment, amount of wages attributable to qualified employment and the amount of covered wages, the total amount deducted from wages and paid for the family share of the premium, and other information specified by the Secretary of Labor.

Each employer (including experience-rated employers) shall provide, in accordance with section 1604(e)(4), the following information on an annual basis:

(A) Health care coverage area information. With respect to each health care coverage area to which employer premium payments were payable in the year:

(i) For each qualifying employee in the year, the total number of months of full-time equivalent employment (as determined under section 1901(b)(2)) for the employee for each class of enrollment and the total amount deducted from wages and paid for the family share of the premium of the qualifying employee.

(ii) The total employer premium payment made under section 6121 for the year with respect to the employment of all qualifying employees residing in the coverage area and, in the case of an employer that has obtained (or seeks to obtain) a premium discount under section 6123, the total employer premium payment that would have been owed for such employment for the year but for such section.

(iii) The number of full-time equivalent employees (determined under section 1901(b)(2)) for each class of family enrollment in the year (and for each month in the year in the case of an employer that has obtained or is seeking a premium discount under section 6123).

(iv) In the case of an employer to which section 6124 applies in a year, such additional information as the Secretary of Labor may require for purposes of that section.

(v) The amounts paid (and payable) pursuant to section 6125.

(vi) The amount of covered wages for each qualifying employee.

Each employer (including experience-rated employers) shall provide, in accordance with section 1604(c)(4), the following information on a monthly basis:

(A) The identity of each eligible individual who changed qualifying employee status with respect to the employer in the month; in the case of such an individual described in subparagraph (B)(i), the consumer purchasing cooperative for the area in which the individual resides and such individual's class of family enrollment.

(B) Changes in qualifying employee status described.—For purposes of subparagraph (A), an individual is considered to have changed qualifying employee status in a month if the individual either

(i) Is a qualifying employee of the employer in the month and was not a qualifying employee of the employer in the previous month, or

(ii) Is not a qualifying employee of the employer in the month but was a qualifying employee of the employer in the previous month.

Each employer (whether or not the employer claimed (or claims) an employer premium discount under section 6123 for a year) that is liable for employer premium payments for any month in a year shall provide such information as may be required (consistent with rules of the Secretary of Labor) to determine the appropriate amount of employer premium payments that should have been made for all months in the year (taking into account any employer premium discount under section 6123 for the employer). Such reconciliation process shall be conducted by the State (with respect to community-rated employers) and by the Secretary of Labor (with respect to experience-rated employers).

The Board shall provide for the use of the health care data network to perform information clearinghouse functions under this section with respect to employers, States, the Federal Government and consumer purchasing cooperatives. The functions referred to above shall include receipt of information submitted by employers under subsection, from the information received, transmittal of information required to States, and such other functions as the Board specifies.

Sec. 6208. Equal voluntary contribution requirement

If an employer makes available a voluntary employer premium payment (as defined in subsection (d)) on behalf of a full-time employee (as defined in section 1901(b)(2)(C)) who is enrolled in a community-rated health plan of a health care coverage area in a class of family enrollment, the employer shall make available such a voluntary employer premium payment in the same dollar amount to all qualifying employees (as defined in section 1901(b)(1)) of the employer who are enrolled in any community-rated health plan of the same coverage area in the same class of family enrollment.

If an experience-rated employer makes available a voluntary employer premium payment on behalf of a full-time employee who is enrolled in an experience-rated health plan of a large group purchaser in a class of family enrollment in a premium area, the employer shall make available such a voluntary employer premium payment in the same dollar amount to all qualifying employees of the employer enrolled in any experience-rated health plan of the same purchaser in the same class of family enrollment in the same premium area.

In applying these rules in the case of a qualifying employee employed on a part-time basis, the dollar amount shall be equal to the full-time employment ratio (as defined in section 1901(b)(2)(B)) multiplied by the dollar amount otherwise required.

An employer may not make available a voluntary employer premium payment on behalf of an employee (enrolled in a community-rated health plan of a health care coverage area in a class of family enrollment) in an amount that exceeds the maximum amount that could be payable as the family share of premium for the most expensive community-rated health plan of the same area for the same class of family enrollment.

An employer may not make available a voluntary employer premium payment on behalf of an employee (enrolled in an experienced-rated health plan of a large group purchaser in a class of family enrollment in a premium area, in an amount that exceeds the maximum amount that could be payable as the family share of premium for the most expensive experienced-rated health plan of the same purchaser for the same class of family enrollment in the same premium area.

An employer may not discriminate in the wages or compensation paid, or other terms or conditions of employment, with respect to an employee based on the health plan (or premium of such a plan) in which the employee is enrolled.

If an employer makes available a voluntary employer premium payment on behalf of an employee, and the sum of the amount of the applicable family credit (under section 6103) and the voluntary employer premium payment, exceeds (ii) the premium for the plan selected, the employer must rebate to the employee and amount equal to the excess.

These rules other than limits on the amount of plan contributions described above shall not apply with respect to voluntary employer premium payments made pursuant to a bona fide collective bargaining agreement.

In this section, the term "voluntary employer premium payment" means any payment designed to be used exclusively (or primarily) toward the cost of the family share of premiums for a health plan. Such term does not include any employer premiums required to be paid under part 3 of subtitle B of title VI.

Sec. 6209. Payment arrangement.

In the case of a family that includes a qualifying employee of an employer, the employer shall deduct from the wages of the qualifying employee (in a manner consistent with any rules of the Secretary of Labor) the amount of the family share of the premium for the plan in which the family is enrolled. In the case of a family

that includes more than one qualifying employee, the family shall choose the employer to which the withholding will apply. Amounts withheld shall be maintained in a manner consistent with standards established by the Secretary of Labor and paid in a manner consistent with the payment of employer premiums under subtitle C. An amount deducted from wages of a qualifying employee by an employer is deemed to have been paid by the employee and to have satisfied the employee's obligation under to the extent of such amount.

In the case of a family that does not include a qualifying employee, the State shall require payment to be made prospectively. Such payment may be required to be made not less frequently than monthly. The Secretary may issue regulations in order to assure the timely and accurate collection of the family share due.

Payment of employer premiums under section 6121 for a month shall be made not less frequently than monthly (or quarterly in the case of such payments made by virtue of section 6126). The Secretary of Labor may establish a method under which employers that pay wages on a weekly basis are permitted to make such employer payments on such a weekly or biweekly basis. A State may require those employers that have the capacity to make payments by electronic transfer to make payments under this subsection by electronic transfer.

Sec. 6210. Enforcement of premium obligations.

The Secretary of Labor, in consultation with the Secretary of Health and Human Services, shall establish an expedited collection process to be implemented in the event of nonpayment of premiums by an employer or an individual. The Secretary of Health and Human Services (in the case of nonpayment by individuals) and the Secretary of Labor (in the case of nonpayment by employers) may impose appropriate penalties including premium surcharges and civil monetary penalties in the amount of \$5,000, or three times the amount of the liability owed, whichever is greater, to enforce the collection of amounts established under subtitle B of this title.

The Federal Government may delegate its responsibilities under this section to a State, upon agreement by such State, if in the judgment of the Secretary of Health and Human Services and the Secretary of Labor such State would provide for the effective enforcement of premium obligations.

Sec. 6211. Determination of uniform per capita conversion factor

Based on directions from the Board, each State will calculate the uniform per capita conversion factor to convert the per capita community and cooperative rates into premiums for the individual class of enrollment.

Title VIII

Sec. 8401. Group health plan defined

Section 3 of the Employee Retirement Income Security Act is amended by adding a new definition as section 42 of that act: "(42)

The terms 'group health plan' means an employee welfare benefit plan which provides medical care (as defined in section 2139d) of the Internal Revenue Code of 1986) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise."

Sec. 8402. Limitation on coverage of group health plans under title I of ERISA

(a) IN GENERAL.—Section 4 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1003) is amended—

(1) in subsection (a), by striking "subsection (b)" and inserting "subsections (b) and (c)";

(2) in subsection (b), by striking "The provisions" and inserting "Except as provided in subsection (c), the provisions"; and

(3) by adding at the end the following new subsection:

"(c) COVERAGE OF GROUP HEALTH PLANS

"(1) LIMITED INCLUSION.—This title shall apply to a group health plan only to the extent provided in this subsection.

"(2) Coverage under certain provisions with respect to certain plans.

"(A) IN GENERAL.—Except as provided in subparagraph

(B), parts 1, 4, 5, and 6 of subtitle B shall apply to

"(i) a group health plan which is maintained by

"(I) a corporate alliance (as defined in section 1311(a) of the Health Security Act), or

"(II) a member of a corporate alliance (as so defined) whose eligible sponsor is described in section 1311(b)(1)(C) (relating to rural electric cooperatives and rural telephone cooperative associations), and

"(ii) a group health plan not described in clause (i) which provides benefits which are permitted under paragraph (4) of section 1003 of the Health Security Act.

"(B) SUPPLEMENTAL PLANS.—The Secretary shall provide by regulation for treatment as a separate group health plan of any arrangement which would otherwise be treated under this title as part of a group health plan to the extent necessary to carry out the purposes of this title.

"(3) CIVIL ACTIONS.—Sections 502(a)(1)(B) of this act (with respect to the cause of action for the recovery of benefits) shall not apply to action by participants, beneficiaries and fiduciaries governed under subtitle C of title V of the Health Security Act.

"(4) DEFINITIONS AND ENFORCEMENT PROVISIONS.—Sections 3, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, and 511 and the preceding subsections of this section shall apply to a group health plan to the extent necessary to effectively carry out, and enforce the requirements under, the provisions of this title as they apply pursuant to this subsection.—

"(5) APPLICABILITY OF PREEMPTION RULES.—Section 514 shall apply in the case of any group health plan to which parts 1, 4, and 6 of subtitle B apply under paragraph (2)."

(b) STATE-CERTIFIED PLANS.—Section 514 of ERISA is amended—

(1) in subsection (b)(2)(A), by inserting "state-certified health plans" after "insurance"; and

(2) in subsection (b)(2)(B), by inserting ", state-certified health plan," before "other insurer".

(c) REPORTING AND DISCLOSURE REQUIREMENTS APPLICABLE TO GROUP HEALTH PLANS.—

(1) IN GENERAL.—Part 1 of subtitle B of title I of such act is amended

(A) in the heading for section 110 (29 U.S.C. 1030), by adding "by pension plans" at the end;

(B) by redesignating section 111 (29 U.S.C. 1031) as section 112; and

(C) by inserting after section 110 the following new section:

"SPECIAL RULES FOR GROUP HEALTH PLANS

"SEC. 111. (a) IN GENERAL.—The Secretary may by regulation provide special rules for the application of this part to group health plans which are consistent with the purposes of this title and the Health Security Act and which take into account the special needs of participants, beneficiaries, and health care providers under such plans.

"(b) EXPEDITIOUS REPORTING AND DISCLOSURE.—Such special rules may include rules providing for

"(1) reductions in the periods of time referred to in this part,

"(2) increases in the frequency of reports and disclosures required under this part, and

"(3) such other changes in the provisions of this part as may result in more expeditious reporting and disclosure of plan terms and changes in such terms to the Secretary and to plan participants and beneficiaries, to the extent that the Secretary determines that the rules described in this subsection are necessary to ensure timely reporting and disclosure of information consistent with the purposes of this part and the Health Security Act as they relate to group health plans.

"(c) ADDITIONAL REQUIREMENTS.—Such special rules may include rules providing for reporting and disclosure to the Secretary and to participants and beneficiaries of additional information or at additional times with respect to group health plans to which this part applies under section 4(c)(2), if such reporting and disclosure would be comparable to and consistent with similar requirements applicable under the Health Security Act with respect to plans maintained by regional alliances (as defined in such section 1301 of such act) and applicable regulations of the Secretary of Health and Human Services prescribed thereunder."

(2) CLERICAL AMENDMENT.—The table of contents in section 1 of such act is amended by striking the items relating to sections 110 and 111 and inserting the following new items:

"Sec. 110. Alternative methods of compliance by pension plans.

"Sec. 111. Special rules for group health plans.

"Sec. 112. Repeal and effective date."

(d) EXCLUSION OF PLANS MAINTAINED BY REGIONAL ALLIANCES FROM TREATMENT AS MULTIPLE EMPLOYER WELFARE ARRANGE-

MENTS.—Section 3(40)(A) of such Act (29 U.S.C. 1002(40)(A)) is amended

(1) in clause (ii), by striking “or”;

(2) in clause (iii), by striking the period and inserting “, or”; and

(3) by adding after clause (iii) the following new clause:

“(iv) by a regional alliance (as defined in section 1301 of the Health Security Act).”.

(e) APPLICATION OF CERTAIN ERISA PROJECTIONS TO ENROLLED INDIVIDUALS.—Certain provisions of sections 510 and 5111 of ERISA shall apply, in relations to the provisions of this act, in relation to individual enrolled or eligible to enroll under large group purchaser plans in the same manner that such provisions apply to participants and beneficiaries under employee welfare benefit plans covered by ERISA.

Sec. 8403. Amendments relating to continuation coverage

(a) PERIOD OF COVERAGE.—Subparagraph (D) of section 602(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1162(1)) is amended—

(1) by striking “or” at the end of clause (i), by striking the period at the end of clause (ii) and inserting “, or”, and by adding at the end the following new clause:

“(iii) eligible for coverage under a comprehensive benefit package described in section 1101 of the Health Security Act.”, and

(2) by adding at the end thereof the following: “An individual whose employment has been terminated by an employer offering health plans through a large group purchaser must elect within 30 days of the termination to either remain in the plans provided by the employer for a period not to exceed 12 months or until the individual is reemployed, whichever is less, or purchase from another plan in the marketplace.”

(3) by striking “or medicare entitlement” in the heading and inserting “, medicare entitlement, or health security act eligibility”.

(b) QUALIFIED BENEFICIARY.—Section 607(3) of such act (29 U.S.C. 1167(3)) is amended by adding at the end the following new subparagraph:

“(D) Special rule for individuals covered by health security act. The term ‘qualified beneficiary’ shall not include any individual who, upon termination of coverage under a group health plan, is eligible for coverage under a comprehensive benefit package described in section 1101 of the Health Security Act.”

(c) REPEAL UPON IMPLEMENTATION OF HEALTH SECURITY ACT.

(1) In general. Part 6 of subtitle B of title I of such act (29 U.S.C. 601 et seq.) is amended by striking sections 601 through 608 and by redesignating section 609 as section 601.

(2) CONFORMING AMENDMENTS.—

(A) Section 502(a)(7) of such act (29 U.S.C. 1132(a)(7)) is amended by striking “609(a)(2)(A)” and inserting “601(a)(2)(A)”.

(B) Section 502(c)(1) is amended by striking “paragraph (1) or (4) of section 606 or”.

(C) Section 514 of such act (29 U.S.C. 1144) is amended by striking "609" each place it appears in subsections (b)(7) and (b)(8) and inserting "601".

(D) The table of contents in section 1 of such act is amended by striking the items relating to sections 601 through 609 and inserting the following new item:

"SEC. 601. ADDITIONAL STANDARDS FOR GROUP HEALTH PLANS."

(d) EFFECTIVE DATE.—

(1) SUBSECTIONS (a) AND (b).—The amendments made by subsections (a) and (b) shall take effect on the date of the enactment of this act.

(2) SUBSECTION (c).—The amendments made by subsection (c) shall take effect following the full implementation of universal coverage.

(e) AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT.—Similar amendments are made in 2202(2)(D) of the Public Health Service Act to provide for the continuation of health insurance coverage.

Sec. 8404. Additional amendments relating to group health plans

(a) REGULATIONS OF THE NATIONAL HEALTH BOARD REGARDING CASES OF ADOPTION.—Section 601(c) of the Employee Retirement Income Security Act of 1974 (as redesignated by section 8403) is amended by adding at the end the following new paragraph:

"(4) Regulations by national health board. The preceding provisions of this subsection shall apply except to the extent otherwise provided in regulations of the National Health Board under the Health Security Act."

(b) COVERAGE OF PEDIATRIC VACCINES.—Section 601(d) of such act (as redesignated by section 8403) is amended by adding at the end the following new sentence: "The preceding sentence shall cease to apply to a group health plan upon becoming a corporate alliance health plan pursuant to an effective election of the plan sponsor to be a corporate alliance under section 1311 of the Health Security Act."

(c) TECHNICAL CORRECTIONS.—Effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1993—

(1) Subsection (a)(2)(B)(ii) of section 609 of the Employee Retirement Income Security Act of 1974 is amended by striking "section 13822" and inserting "section 13623".

(2) Subsection (a)(4) of such section 609 is amended by striking "section 13822" and inserting "section 13623".

(3) Subsection (d) of such section 609 is amended by striking "section 13830" and inserting "section 13631".

Sec. 8405. Plan claims procedures

Section 503 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1133) is amended—

(1) by inserting "(a) In General." after "Section 503."; and

(2) by adding at the end the following new subsection:

"(b) GROUP HEALTH PLANS.—In addition to the requirements of subsection (a), a group health plan to which parts 1 and 4 apply under section 4(c)(2) shall comply with the requirements of section

5201 of the Health Security Act (relating to health plan claims procedure).”.

Sec. 8406. Preemption of Hawaii Prepaid Health Care Act

(a) IN GENERAL.—Section 514(b)(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(5)) is amended to read as follows:

“(5)(A) Except as provided in subparagraphs (B) and (C), subsection (a) shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat.—1A393–091 through 393–0951).

“(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) any State tax law relating to employee benefits plans.

“(C) If the Secretary of Labor notifies the Governor of the State of Hawaii that as the result of an amendment to the Hawaii Prepaid Health Care Act enacted after the date of the enactment of this paragraph—

“(i) the proportion of the population with health care coverage under such Act is less than such proportion on such date, or

“(ii) the level of benefit coverage provided under such Act is less than the actuarial equivalent of such level of coverage on such date, subparagraph (A) shall not apply with respect to the application of such amendment to such Act after the date of such notification.”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this act.

Title IX. Aggregate Government Payments

SUBTITLE B. AGGREGATE FEDERAL PAYMENTS TO PARTICIPATING STATES

Subtitle B describes payments by the Federal Government to States for the Federal share of premiums.

Sec. 9100. Capped Federal payments

(a) Beginning January 1, 1996, the Secretary must provide to each State payments for family and employer discounts (“capped Federal payment amount,” as defined in this section). The total amount of these payments is a capped entitlement.

The Federal Government is not responsible for amounts owed to a plan but not collected, for administrative errors in providing discounts that exceed maximum permissible error rates, or for misappropriations or other expenditures that the Secretary finds are attributable to malfeasance or misfeasance by the plan or the State.

For a single-payer State, the Secretary must pay an amount equal to what regional alliances in the State would have received under this section if the State were not a single-payer State.

The capped Federal payment amount must be made on a periodic basis, reflecting the cash flow requirements of plans and States.

The total amount of the capped Federal alliance payments for a fiscal year may not exceed \$285 billion in the fiscal years 1996–

2000. The National Health Board shall apportion this amount among fiscal years.

If the Secretary anticipates that the amount of the cap, plus any amount carried forward from a previous year, will not be sufficient for a fiscal year, the Secretary must notify the President, the Congress, and each State of the anticipated shortfall and when the shortfall will first occur.

Within 30 days of receiving notice from the Secretary, the President must submit to Congress a report containing specific legislative recommendations for actions which would eliminate the shortfall.

The President's report is considered under an expedited process. If a joint resolution is introduced that contains the President's recommendations, that resolution is considered in a manner described in the Defense Base Closure and Realignment Act of 1990.

SUBTITLE C. BORROWING AUTHORITY TO COVER CASH-FLOW SHORTFALLS

Sec. 9200. Borrowing authority to cover cash-flow shortfalls

The Secretary shall make available loans for estimation discrepancies and to cover periods of temporary cash-flow shortfall relating to administrative errors or the relative timing during the year in which amounts are payable and receivable.

Sec. 9201. Contingencies

Each State shall provide for discrepancy funds to cover shortfalls resulting from estimation discrepancies.

Title X. Workers Compensation Medical Services

Sec. 10000. Application of information requirements

Provides that the provisions of the act relating to the use of standard forms and the reporting of health care information apply to the provision of workers compensation medical services by a health care plan or provider in the same manner as they apply to the provision of services included in the comprehensive benefit packages. Directs the Secretary of Labor to promulgate rules to clarify the responsibilities of health plans and health care providers in carrying out these provisions.

Requires health care plans and providers that render workers compensation medical services to provide to the worker and to the workers compensation carrier and/or employer relevant health care information necessary to assist the worker in the safe and timely return to work, and to comply with legal duties and reporting requirements under applicable State and Federal laws.

Sec. 10001. Provision of care in disputed cases

Provides that in cases in which a workers compensation claim is challenged by the employer and/or the workers compensation carrier, the worker's health plan shall provide or pay for all medical care included in the comprehensive benefits package until such time as a determination is made that the claim is compensable as a workers compensation claim. If the claim is determined to be compensable, the workers compensation carrier (or the employer, if

self-insured) is required to reimburse the health plan (for the cost of services delivered) and the worker (for any copayments, deductibles or coinsurance costs incurred).

Sec. 10002. Demonstration projects

Authorizes the Secretary of Health and Human Services and the Secretary of Labor to conduct demonstration projects in one or more States with respect to the treatment of work-related injuries and illnesses, develop protocols for the appropriate treatment of work-related conditions, enter into contracts with community-rated plans to test the validity of the protocols, and develop methods of providing for payment by workers compensation carriers to health plans on a per case, capitated basis.

Sec. 10003. Commission on Workers Compensation Medical Services

Establishes a 15-member Commission on Workers Compensation Medical Services to study the relationship of workers compensation medical services to the new health system established under the act in terms of impact on the cost of workers compensation medical services, access to appropriate care for injured workers, and quality of medical care and its impact on functional and vocational outcomes for injured workers. The Commission is authorized to issue such interim reports on matters addressed by the Commission as its members determine to be appropriate. The Commission's final report is required to be submitted to the President and to the labor committees of the Senate and House of Representatives no later than October 1, 2000, and shall include a recommendation as to whether a transfer of financial responsibility for some or all workers compensation medical benefits should be effected, together with a detailed implementation plan if the Commission recommends such a transfer.

Title XI. Transitional Insurance Reform

Sec. 11001. Imposition of requirements

This title provides for requirements to assure the maintenance of current health care coverage and benefits during transition period.

The Secretary of Health and Human Services will enforce the requirements of the title with respect to health insurance plans and the Secretary of Labor will enforce the requirements with respect to self-funded health plans.

The Secretaries are authorized to enter into arrangements with a state to enforce the requirements of this title with respect to health insurance plans and self-insured plans providing coverage in the state.

Sec. 11002. Enforcement

A health insurer or health benefit plan sponsor that violates a requirement of this title is subject to civil money penalties of not more than \$25,000 for each such violation.

Sec. 11003. Requirements relating to preserving current coverage

Generally prohibits health insurers from terminating (or failing to renew) coverage under a group or individual premiums, fraud, or misrepresentation of a material fact relating to an application for coverage or claim for benefits.

Health insurers that provide group health insurance plans are required to provide coverage to new full-time employees (and their eligible dependents) of any employer covered under the plan. Premium rates for new employees must be consistent with the provisions of section 11004(b) and any exclusions imposed for preexisting conditions must meet the requirements of section 11005.

Sec. 11004. Restrictions on premium increases during transition

This section establishes requirements relating to premium increases by health insurers during the transition period.

Sec. 11005. Requirements relating to portability

Limits the period of exclusion that a group health benefit plan may apply with respect to services related to treatment of a preexisting condition to a period of not more than 6 months. An exclusion of coverage for treatment of a preexisting condition may not apply to services furnished to newborns or in the case of a plan that did not apply such exclusions as of the effective date of this title.

A group health benefit plan must reduce any period of exclusion applied with respect to treatment of a preexisting condition for individuals that were previously covered by health insurance. The previous coverage must have been continuous (with no more than three consecutive months without coverage).

Self-insured plans and employers sponsoring group health insurance plans may not discriminate among employees in the establishment of waiting periods for health insurance on the basis of health status or related factors.

Sec. 11006. Requirements limiting reduction of benefits

A sponsor of a self-insured benefit plan may not modify benefits under the plan to limit coverage with respect to any medical condition or course of treatment for which the anticipated cost is likely to exceed \$5,000 in any 12-month period.

Sec. 11007. National Transitional Health Insurance Risk Pool

Authorizes the Secretary to establish a National Transitional Health Insurance Risk Pool for individuals who are unable to secure private health insurance because of their health status or condition during the transition.

Sec. 11008. Definitions

Provides definitions to terms used in this title.

Sec. 11009. Termination

The provisions of this title only apply until the transition period.

VIII. COMMITTEE VIEWS

OVERVIEW

The committee concludes that the Health Security Act is an effective solution to the problems of assuring affordable, comprehensive health insurance coverage to all Americans, and controlling the excessive inflation in health care costs. When the program is fully implemented, every American will be guaranteed affordable private health insurance coverage or will be covered through the current Medicare program for senior citizens and the disabled. In addition, the program addresses the special needs of senior citizens and younger Americans with disability by providing a phased-in program of home care and personal assistance, as well as a new national, voluntary program of health insurance coverage. Prescription drug coverage is assumed to be added to the Medicare program.

Costs will be controlled by establishing a universal system under which competition and market forces can finally be brought to bear in health care. Competition and market forces have been the engine driving quality improvement and improved efficiency in many parts of the private sector. The time is overdue to put these constructive forces to work in health care, where costs have been rising faster for decades than our economy, our government, or the American people can afford.

The committee recognizes, however, that excess inflation is so deeply imbedded in the health care sector that market forces alone may not bring costs under control quickly enough or effectively enough in every area of the country. In addition, as every analyst of the health care system knows, extensive third party reimbursement—essential to assure the American people access to needed medical care at an affordable price—makes the application of market forces more complicated.

Accordingly, the committee has maintained in the Health Security Act, as reported, the system of backstop premium limits contained in the bill as proposed by the President. These backstop premium limits will help control costs in areas where competition control costs effectively. Equally important, the presence of these premium limits sends a strong signal to the health care system as a whole that efficiency and elimination of unreasonable cost increases must be a priority. The Congressional Budget Office has estimated that the cost control program included in the President's bill will reduce national health expenditures by more than \$330 billion over the next 10 years below what they would be under current policies, while extending health insurance coverage to every American.

Finally, the committee recognizes that a health insurance card alone is not sufficient to guarantee quality health care or the best possible health for all the American people. People in underserved rural and urban areas may not receive the care they need even if they are insured, because of a lack of providers. Some populations need special services, such as outreach or transportation, to gain access to the care they need. Some of the most effective and important prevention activities are not provided in a doctor's office,

where they would be covered by insurance, but in the community or the work place.

To achieve the best quality care for our nation, we need an expanded investment in biomedical, clinical, and health services research, a diffusion of the fruits of that research into doctors' offices and hospitals around the country, and a maintenance of the most advanced tertiary care facilities. We need adequate information systems to measure the quality of care and hold providers and plans accountable. We also need to support programs for health personnel training that will continue to ensure that our country has the best trained health providers in the world.

The Health Security Act, as reported by the committee, is designed to address these additional issues. The bill includes substantially expanded investment in health infrastructure for underserved areas, such as community health centers and the National Health Service Corps and provides funding for "enabling services" to help populations that need special assistance to actually receive services. It provides additional funds for prevention activities and creates a new program to reduce occupational injury and disease. It establishes a new program of support for physician training and advanced practice nurse training that will increase the supply of primary care providers. It provides additional support for academic health centers and teaching hospitals to assure that these institutions, which are so important to quality care, research, and training can continue to flourish in an environment where competitive forces are far more important. Investment in biomedical health services research is dramatically increased. And the plan provides for a 21st century program of health data collection and analysis, so that quality can be measured and improved.

In approving the Health Security Act, the committee carefully considered and rejected a number of concerns expressed by opponents of the bill, or modified the legislation to address their concerns. These concerns included:

Fear that the system of mandatory regional alliances established by the bill would create unresponsive monopolies and might make it impossible for large businesses to play a constructive role in cost containment.

Contentions that the system of shared responsibility established by the bill would place an unreasonable burden on the economy and small business and would lead to substantial job loss and harm to the economy;

Arguments that the system of fall-back premium limits in the bill would stifle competition and would lead to rationing of health care services;

Charges that the act, by establishing a national guarantee of coverage, would also create Government control of the practice of medicine and limit the choices that individuals have today.

Allegations that the program creates massive new public obligations that would raise the deficit.

Regional alliances

The original version of the Health Security Act submitted by the President required every American not covered by Medicare and not employed by a business with 5,000 or more workers to obtain

their health insurance coverage through plans offered by regional alliances established by State government. Only one alliance would be established in each geographical area.

Concerns were expressed that these alliances would act as monopolistic purchasers of health insurance, that they would be too disruptive to the existing system for providing coverage, that no alternative would be offered to individuals dissatisfied with the services provided by regional alliances, and that, because such a small share of the labor force would be covered outside the alliance, large employers would be unable to exert sufficient power to have a positive impact on the health care system.

Some of these concerns ignored the specific provisions of the President's bill. For example, alliances were not able to act as monopolistic purchasers of health insurance services, because they were required to offer every health plan certified by the State that was willing to meet standard contractual obligations.

The committee recognized, however, that some of the criticisms were valid and made major changes in the program to address these concerns:

The committee eliminated mandatory alliances altogether. Instead, individuals in the community-rated pool created by the bill could purchase coverage through 5 different sources: (1) their employer, if they were employed; (2) a consumer purchasing cooperative; (3) the Federal Employees Health Benefit Program (FEHBP); (4) directly from a health insurance plan; (5) an insurance agent. This broad array of choices for individuals and employers should eliminate concerns about the monopolistic character of alliances as established under the original bill. Because individuals can continue to buy coverage through employer, agents, and directly from companies, disruption of the current system would be minimized.

The opportunity to purchase coverage through the Federal Employee Health Benefit Program, the source of coverage for Members of Congress, the President, and all other Federal workers as well, offers an especially innovative new option to most Americans.

The Federal Employees Health Benefits Program provides health insurance coverage for 9 million Federal employees, retirees and dependents in all 50 states, Guam and Puerto Rico. Almost all Federal employees are eligible to enroll in FEHBP. More than 400 health plans contract with OPM to provide coverage through FEHBP, including about two dozen fee for service plans. In the Washington, DC, area Federal workers have a choice of more than 30 plans. The FEHBP has an effective track record of assuring quality health insurance offerings to Federal workers, and now this option will be available to all participants in the community-rated pool as well.

Under the new plan, FEHBP would offer coverage in every community-rating area in country. Each plan offered would provide the standard benefits otherwise required under the Health Security Act and would charge a community-rated premium for the particular area.

The committee reduced the size of the community-rated pool, so that large employers outside the pool would be able to continue to be a creative force in the market. Under the bill, as reported, all employers with more than 1,000 employees would be required to

buy health insurance on their own or in combination with other employers and would not be eligible to purchase from the community-rated pool. Employers with between 5000 and 1,000 workers have the option of joining the community-rated pool or staying outside it. Even if no businesses of 500 to 1,000 employees elected to leave the community-rated pool, 36 percent of the work-force and up to 78 million people would be outside the pool.

Shared responsibility

Health insurance in America today is built on a system of shared responsibility among business, individuals, and government. Business provides coverage for most working Americans and their families—almost 90 percent of private insurance coverage for these families is provided through the workplace. Individuals typically contribute to the cost of employment-based coverage. If they are self-employed or not employed, they often purchase their own coverage and pay for it themselves. Government is also part of the partnership. The Federal Medicare program provides coverage for senior citizens and the disabled. The Federal-State Medicaid program provides coverage for welfare recipients and for some low-income Americans who fit into the welfare categories, even though they do not receive cash welfare payments, e.g., families with dependent children. The Government also provides some \$74 billion in tax expenditures annually to help support business contributions to the cost of coverage for workers and their families.

The Health Security Act builds on this system of shared responsibility by extending employment-based coverage to most workers, requiring every individual to purchase health insurance, and by providing substantial discounts for low income individuals and for business needing assistance to provide coverage. The committee modified the original program submitted by the President so that it exempts small, low wage firms with fewer than 10 workers from the general obligation on business to provide coverage to employees and dependents. This change exempts 60 percent of all businesses in America—and provides relief for those businesses that would have the greatest difficulty in complying with the normal requirement to contribute to the cost of coverage. The committee provided additional protection for workers in these exempt firms by limiting the amount they would have to pay for coverage to a maximum of 4 to 6 percent of income.

Burden on the economy. Allegations of damage to the economy and growth in unemployment are standard arguments for those who oppose any Government requirements on business, whether the issue is minimum wage, occupational health and safety, equal rights for the disabled, or medical and family leave requirements.

The committee examined these arguments with regard to the Health Security Act. All credible economic analyses of the impact of the program on business showed a negligible impact on unemployment and, as the result of the cost-containment features of the program, substantial long-term increases in wages or profits. The Congressional Budget Office estimated that business would save \$20 billion annually by the year 2000 and \$90 billion annually by 2004 under the President's plan.

In analyzing the impact of the President's plan on jobs, the CBO concluded that effects on unemployment would be minimal, "falling well within the uncertainty of projections of the labor force and GDP over the next decade." The nonpartisan Employee Benefits Research Institute, using a variety of different assumptions, concluded that employment impacts could range from 160,000 jobs lost (about one-tenth of one percent of total employment) to 660,000 jobs gained (Employee Benefits Research Institute, *An Employer Mandate: What's know and What Isn't.*, November, 1993). Studies by Jacob Klerman and others at the RAND Corp. (*Job Loss Due to Health Care Reform*, RAND Corp., November, 1993), M. Edith Rasell of the Economic Policy Institute (*The Impact of the Clinton Health Care Reform Plan on Jobs, Investment, Wages, Productivity, and Exports*, Economic Policy Institute, November, 1993), and the Council of Economic Advisors (testimony of Laura D'Andrea Tyson, Committee on Labor and Human Resources, October 19, 1993) have reached similar conclusions.

These estimates of minimal employment impact from requiring employers to contribute to the cost of health insurance for their workers are consistent with findings of earlier estimates of proposals previously considered by the Committee, including studies by Professor Karen Davis of Johns Hopkins University, Professor F. Gerard Adams of the University of Pennsylvania, and Professor Ken Thorpe of the University of North Carolina.

The program will also improve the flexibility and productivity of our economy in a number of ways. The cost of health insurance will be distributed more fairly among businesses, so that less efficient firms do not gain a competitive advantage over more efficient firms by failing to provide health insurance. These firms pay family plan premiums that are one-quarter to one-third higher than they would be if other employers paid their fair share (Hewitt Associates, "How Would Businesses React to an Employer Mandate?" January, 1994). With universal coverage, workers will be free to move to new jobs that make the best use of their talents without worrying that they will lose health insurance coverage. According to one study, 25 percent of married men would move to new jobs if not for the problem of potential loss of coverage (Brigitte Madrian, "Employment-Based Health Insurance and Job Mobility," *Quarterly Journal of Economics*, February 2, 1994). As many as one-quarter of all AFDC parents would accept jobs if they could find comparable health insurance coverage through their new employer.

The limited number of studies that have claimed significant unemployment as the result of the Health Security Act have typically been commissioned by opponents of the plan and have been discredited by independent observers. The most widely cited study is by the CONSAD Corp., which has produced a number of studies for opponents of shared responsibility, such as the National Federation of Independent Business, all the way back to the HealthAmerica bill introduced in 1991.

Independent commentary on CONSAD's study of HealthAmerica found the organization's analysis to be lacking in credibility or scientific basis. Professor Thorpe analyzed the study and concluded, "(It) ignores over twenty years of empirical research conducted by a broad array of economists * * * Consad's findings * * * are

based on assumptions which have no empirical basis * * * In short, the assumptions used by Consad appear from thin air, are not referenced, they are not supported by a published economic evaluation and therefore should not be taken seriously as an estimate of the impact on labor supply" (Hearing before the Committee on Labor and Human Resources, July 24, 1991). Professor Karen Davis also analyzed the study and concluded, "This study uses unsubstantiated assumptions which render the findings and conclusions of the report invalid and completely lacking in merit." (Hearing before the Committee on Labor and Human Resources, July 24, 1991).

Studies of the administration plan and the committee program by this organization have not been substantially improved in quality. CBO Director Robert Reischauer commented, "The estimates * * * are highly exaggerated" (Hearing before the Committee on Ways and Means, February 2, 1994). Dr. Karen Davis characterized both the study by CONSAD and one O'Neil and O'Neil (discussed below) as "us(ing) seriously flawed assumptions * * *." She commented that the estimates "are totally out of line with minimum wage studies." (Employment Impact of Employer Premium Mandates: Comment on Two Recent Reports, May 27, 1994). Professor Jonathan Gruber of MIT also analyzed the two studies and concluded, "(T)hese estimates are much too high. These high estimates can be traced directly to unreasonable assumptions * * *. I conclude that the disemployment effects of an employer mandate are likely to be quite small. I think that the studies which find large disemployment effects make erroneous assumptions which are directly responsible for their findings." (letter to Senator Kennedy, May 16, 1994). Professor Alan Kreuger of M.I.T. also reviewed the two studies and concluded, "The credible estimates of any employment loss from the Health Security Act are just a blip when viewed against the backdrop of total U.S. employment, or annual employment growth * * * To put the job loss issue in perspective, suppose that an economic consulting firm were asked to forecast U.S. employment in the year 2000. I doubt very much that this firm's forecast of aggregate U.S. employment for the year 2000 will be meaningfully affected by the impact of an employer mandate to provide health insurance." (letter to Senator Kennedy, May 17, 1994).

The O'Neil and O'Neil study is the second most frequently cited study used to argue that the Health Security Act will cost jobs. It was commissioned by the restaurant industry and suffers from many of the same defects as the CONSAD study, as noted by the authorities cited above.

Independent of the fundamental mistakes in economic analysis made of CONSAD and O'Neil and O'Neil are two generic failings, pointed out by a number of the authorities cited above. First, the studies attempt to estimate the reduction in employment by businesses not now providing coverage and experiencing greater costs as the result of the employer mandate. They do not estimate the increased hiring by businesses that are currently providing coverage and will experience reduced costs as the result of the reduction in cost-shifting and the generous discounts provided by the program.

Second, the studies do not attempt to evaluate the impact of the cost-containment program included in the bill. As the CBO analysis of the program cited above pointed out, over time, businesses will experience substantial reductions in their total spending for health care for their employees.

Damage to small business. The committee recognizes that many small businesses have legitimate concerns about the affordability of new requirements to provide or contribute to health care. The Health Security Act, as reported by the Committee, has been carefully constructed to address these concerns, while maintaining the principle of shared responsibility.

In assessing the impact of the Health Security Act on small businesses, it is important to recognize the problems small businesses that provide or want to provide coverage face today. These firms are the dominant part of the small business economy. More than half the workers in firms with fewer than 25 workers are employed by businesses offering coverage of their employees. Almost two-thirds of workers in firms with less than 100 workers are employed by businesses offering coverage to their employees (Department of Labor, *Trends in Health Benefits*, 1993).

These small firms providing coverage face excessive costs and inequitable treatment. Indeed, after examining current conditions in the small insurance market, the committee concluded that it was far more remarkable that so many small businesses provide health insurance coverage to their workers than that so many did not. For example:

The cost of health insurance for a small business of 25 employees or less averages 25 percent more than a large business would pay for comparable coverage. For businesses with fewer than 10 workers the mark-up compared to a large business can be 35 percent or more. For such firms 40 or even 50 cents of every premium dollar typically stays with the insurance company to cover sales costs, administration, and profit rather than paying for health care services.

Small businesses cannot get coverage at all in today's market if anyone in the business—owners or workers—has significant health problems. Whole categories of small business, e.g., restaurants, are redlined out of health coverage.

Preexisting condition exclusions are an almost universal feature of the small business market, so that owners and employees are not covered for the very illnesses that are most likely to result in a need for expensive health care.

If a small business with a healthy work force does manage to get coverage and someone subsequently gets sick, the small business can either lose coverage or face astronomical price increases.

Small businesses frequently lack access to cost-effective managed care programs. Small businesses are only half as likely to offer health management organizations to their employees as large businesses.

Small businesses lack the bargaining power to protect themselves against the cost-shifts that are such an important component of today's health care prices. The Prospective Payment Assessment Commission recently estimated that hospital charges to private payers are now marked up an average 30 percent above costs to

cover the costs of services to the uninsured and underpayment by Medicare, Medicaid, and other public programs. For private payers who are not in a position to negotiate discounts of their own, the mark-up is even higher.

Given the disadvantages small businesses face in providing health insurance to their employees, the committee concluded that the Health Security Act will provide substantial assistance for small business. The program includes a number of major provisions to assist small business:

As approved by the Committee, small businesses with 10 employees or fewer and average wages of less than \$24,000—the “mom and pop” businesses that might have the most difficulty in affording health insurance for their workers—are exempted from the requirement to provide coverage. These firms account for 60 percent of all American business. In keeping with the principle of shared responsibility, these firms are expected to make a payroll contribution to the overall cost of the program of 1 percent (for firms with 5 or fewer workers) or 2 percent (for firms with 6–10 workers). For a minimum wage worker, this obligation amounts to less than a quarter a day for the one percent obligation and less than 50 cents for the two percent obligation. While these firms will not have to bear the cost of providing coverage, their workers will be guaranteed affordable health insurance, so that they will be in a much better position to attract qualified employees than they are today.

Firms with fewer than 10 workers and low average wages that wish to continue or start to contribute to coverage for their workers will be offered generous discounts—as will larger small firms with low wages. For the smallest, lowest wage firms, the cost will be limited to 4.2 percent of the salary of any worker. For a \$10,000 a year worker with a family, the businesses obligation would be just \$420, a discount of \$2,613 from the estimated cost of \$3,033 for an employer paying the normal business obligation.

A more prosperous small firm, with high average wages would qualify—along with businesses of all sizes—for a limit on its obligation to provide coverage of 12 percent of the salary of any worker. For higher wage employees, the cost of coverage will be far less than 12 percent of salary, but for low wage workers such as the \$10,000 a year worker mentioned above, the savings will be substantial.

Some attacks on the program have erroneously categorized these discounts as a payroll tax. In fact, they are subsidies designed to reduce employer liabilities and make the program more affordable. For example, the 12 percent cap would mean a substantial reduction in employer cost for a low wage employee, but for most employees, the employer’s financial obligation will be far less than 12 percent of wages. Moreover, the discounts not only assist firms that will be providing coverage to their workers for the first time, they will provide substantial relief to the greater number of firms that are already providing coverage but struggling to afford it.

Because small firms will now be part of very large community rating pools—and will also have the opportunity to join coops or the FEHBP—they will collectively have the same market power that only the largest firms enjoy today. They will no longer face the cost-shifting so characteristic of the current market.

Health insurance reform will guarantee access to health insurance coverage at an affordable community rate, regardless of health status of employees or owners.

Pre-existing condition exclusions will be abolished.

Small businesses will be guaranteed access to cost-effective managed care.

The committee notes that experience has shown that small business can prosper under a program of mandatory provision of coverage to employees, even without the many special programs contained in the Health Security Act. Hawaii has had such a program in place for two decades. Since then, Hawaii's employment situation has actually improved. Hawaii now boasts one of the lowest unemployment rates of any State in the nation. Moreover, Hawaii has a thriving small business sector, despite mandatory coverage. Ninety-seven percent of Hawaii's businesses employ less than 100 employees; 94 percent employ 50 or less. Hawaii's small business failure rate is only half the national average, and it has been identified as the number one place in the Nation to start a successful small business.

Competition and rationing

Critics of the Health Security Act have characterized the fall-back premium limits under the plan as anti-competitive price-fixing and have charged that they would stifle competition. They have also alleged that they would result in rationing of care.

Premium limits and competition. The program of fall-back premium limits has been carefully constructed to encourage rather than retard competition. Under the program, the National Health Board sets a premium target for each community-rated area in the country. The base for each area is set based on a number of factors, but primarily what is already being spent in the area for covered services. Once the base is established, the target increases at an allowable rate specified in the legislation. The target is for the weighted average of all premiums charged by all plans in the area—not for the premium charged by any particular plan.

Under the program, insurance firms compete to offer the lowest premiums. Because the opportunity for insurance companies to compete by selecting who they will ensure has been eliminated and because the benefit package is standardized, the only basis on which insurance companies can compete is cost and quality.

Just as insurance companies have incentives to offer the lowest possible price, individuals have incentives to choose the most cost-effective plans. Every employer is required to make a level contribution to every plan, so employees pay the additional cost of choosing a more expensive plan out of their own pockets. If employees choose a plan that is less expensive than the employer contribution, they get a cash rebate. Voluntary purchasing cooperatives give bargaining power to small businesses and individuals.

If competition is effective at holding costs below the target, the fall-back premium limits never come into play. Only if competition is not effective enough, do fall-back premium limits apply. The limits never apply to any insurance plan below the target. Instead, if they need to be applied, they are used only to reduce the charges

of high cost plans enough to bring down the average premium for the area as a whole to the target level.

Premium limits are applied 1 year at a time. The following year, if competition is effective in bringing down costs, no further action is taken.

In summary, this program could not be more different from a conventional price-fixing approach to cost control:

No limits apply unless targets are exceeded

Targets are for area-wide average premiums, not for the premiums of any individual company

Firms continue to compete on price

Limits only apply where competition fails and for only as long as competition is ineffective.

The committee established a competition approach relying on market forces to control health care costs as an effective way to deal with excess cost inflation. A market-based approach is the essential method for cost control under the Health Security Act. The committee was mindful, however, that the Congressional Budget Office has concluded that a purely competitive approach to comprehensive health reform could increase the deficit by more than \$300 billion over the next 10 years—and still not achieve universal coverage. Accordingly, the committee concluded that a system of fall-back premium limits was necessary to assure that cost-containment targets were reached. This fall-back system has been carefully crafted to permit market forces and competition to work.

Rationing. The committee also considered allegations that adoption of the Health Security Act would result in rationing of care. Such claims were a staple of the debate over Medicare a generation ago. They had no validity then, and the committee finds that they have no validity today.

Americans without health insurance coverage today or with inadequate coverage find their care rationed based on ability to pay. By contrast, the Health Security Act guarantees not only that all Americans will have insurance but that all medically necessary services covered by the program will be provided, regardless of cost. The committee feels strongly that this prohibition on rationing is essential to maintain the ethical principle that the right to necessary health care should be a fundamental human right.

Rationing can also occur if the health care system as a whole is not receiving sufficient financial support to meet people's needs. While the Health Security Act includes a strong, comprehensive program to control excessive inflation in health care costs—a need recognized by supporters and opponents of the program alike—the program is carefully constructed to address the cost problem by ending cost-shifting, eliminating excessive administrative costs, reducing fraud and abuse, assuring cost-effective preventive care, and introducing market forces and competition to the health care system rather than by denying timely, medically necessary care to any individual.

Even with the strong cost control program included in the legislation, the program does not cut health spending; it only limits the rate of increase to more reasonable levels. According to the Congressional Budget Office, health spending will still be \$600 billion higher in the year 2000 than it is today. Under the Clinton plan,

by the year 2004 health care will grow to 19 percent of GDP (up from 14.9 percent today). Under current law, it will grow to 20 percent of GDP. It strains credibility to believe that the difference between a 4.1 percent increase in the share of GDP going to health and a 5.1 percent increase will strangle our health care system.

By international standards, the spending targets contained in the bill are generous. Spending increases under the plan are still higher than eight other major countries (France, England, Canada, Japan, Germany, Netherlands, Denmark, and Sweden) with good health systems have achieved, even though they start from a much lower spending base. From 1980 to 1991, these countries averaged an annual rate of spending increase of 2.4 percent a year per capita in excess of inflation. During the first 5 years of the Health Security Act, health care spending is projected to increase by 4.2 percent a year in excess of inflation.

Opponents of the Health Security Act sometimes erroneously compare the target rates of increase in health insurance premiums under the plan to total rates of growth in other countries. But these comparisons are inappropriate, because the premium targets do not affect spending for senior citizens—the section of the population with the fastest growing costs in all countries—as well as services not covered by the standard benefit package. It is also ironic, that many of the most vocal critics of the Health Security Act in the Senate voted for limits on per capita growth in spending for senior citizens under Medicare and poor people under Medicaid that are tighter than the premium targets proposed under the HSA. Finally, the premium targets are only specified in legislation for the first 5 years. In subsequent years, the National Health Board recommends the appropriate level to Congress based on the needs of our health care system. The fall-back target, if Congress fails to act, is set at a level that is significantly higher than the target during the first 5 years.

In addition to international comparisons, a simple examination of our current wasteful system shows opportunities for huge savings that would not reduce and might actually improve quality of care. Twenty-five percent of all health care spending goes toward administration. The average hospital has 3 times as many administrators today as it did in 1968 but treats fewer patients.

As much as 40 percent of hospitalizations could be avoided with timely outpatient care. Hospital occupancy rates are less than 70 percent. Doctors' services for Medicare patients cost less than half as much per patient in San Francisco as they do in Miami, without any apparent differences in quality of care. The Rand Corp., after a thorough review of the literature, concluded that between 20 and 25 percent of all hospital services or procedures were unnecessary or inappropriate. The GAO has estimated that as much as \$90 billion in annual health costs are the result of fraud.

Private sector efforts have already shown that costs can be cut without harming quality. The Mayo Clinic's cost growth has been held at half the national average since 1988. Costs per patient were actually cut 2.4 percent last year. Over the last two years, the CalPers program has averaged only about 1.8 percent a year premium growth, and will actually reduce premiums next year. In Massachusetts, a coalition of private sector purchasers held rate

hikes to 6.4 percent and are planning no increases for next year. Rochester, New York, has reduced its health insurance costs to one-third below the national average by efficient use of hospitals and health planning. The Scripps Institute of Medicine has actually *cut* costs 5 to 20 percent per diagnosis. General Mills cut its health care costs 25 percent between 1991 and 1992 by negotiating with health plans over price and quality. The Orange County (FL) school district cut costs 11 percent in the same period.

Finally, preventive care—a hallmark of the Health Security Act—can reduce costs. Every dollar spent on immunizations saves \$10. Hawaii's emphasis on prevention results in 10 percent fewer hospital days than the national average and 42 percent fewer surgeries. Since 1982, the State economy as a whole has been growing faster than the health sector. While Hawaii has one of the highest breast cancer rates in the country, it has one of the lowest death rates—because of early diagnosis and treatment.

No one supports the idea that health care spending should continue to grow at its current rate. The committee finds that the Health Security Act presents a moderate, responsible program to reduce the growth in health care spending to more reasonable levels.

Government control over the practice of medicine and limitations on choice. Like the allegation that the Health Security Act would lead to rationing, charges that it would lead to Government control over the practice of medicine and limitation on choice are no more true today than similar allegations were with regard to the Medicare program. The Health Security Act maintains America's private health care system, and expands its benefits to all our citizens.

The committee finds that the Health Security Act would expand, rather than limit consumer choice in many areas. Many Americans regard their ability to freely choose their own doctor and hospital to be one of the most valuable components of the American health care system. Second to choice of doctor and hospital is freedom to choose a health plan, since choice of a health plan—if a network plan is chosen for reasons of cost and quality—determines what group of doctors and hospitals a patient can choose.

The Health Security Act, not only maintains the elements of choice in the current system, it also provides guarantees of choice that do not currently exist. Today, a working family generally can only afford to enroll in a health plan chosen by their employer. Half of all the workers in America no longer have a choice of health plans. Less than one-third of all firms with fewer than 500 employees offer a choice of plan. Increasingly, employees must choose a network plan that limits their choice of doctor and hospital. When the employer changes insurance policies, the worker must change doctors.

Under the Health Security Act, every individual is guaranteed a choice of health plans—and at least one of the plans they are offered must provide for full freedom of choice of provider. Employees of the largest companies must be offered at least 3 health plans, one of which must provide for freedom of choice. The majority of Americans will participate in community-rated pools, where a broad choice of plans is assured—through consumer purchasing co-operatives and through the opportunity to enroll in one of the plans

offered by the Federal Employees Health Benefit Program. Again, the option to enroll in at least one plan offering freedom of choice of provider is guaranteed.

Finally, the committee notes that opponents of the plan have circulated spurious allegations that individuals would not be able to go to a physician or other provider of their choice and pay for services out of their own pocket, rather than having their insurance cover the cost. In the unlikely event that some one would want to make an arrangement of this kind, section 1003 of the act specifically guarantees this right.

Benefits

Opponents of the Health Security Act have complained that the benefit package was too generous and expensive. In addition, some have argued that the package should be left to decisions of an independent board.

Generosity of the package. The committee found that key goals of universal coverage are to assure that people have access to the health services they need and that they have adequate financial protection against the costs of serious illness. Health insurance is of no benefit to an individual whose illness is not covered, or if the specific service needed is excluded from the package. Artificial limits on service-only 10 visits to a physician a year or 30 days in the hospital, for example—also defeat the goal of universal coverage, because they mean inadequate protection for those who are most seriously ill. For these reasons, the committee chose to approve legislation providing comprehensive benefits and avoided limitations on any services other than medical necessity whenever possible. The committee also concluded that broad coverage of preventive services without deductibles or copayments was a good investment.

The benefits approved by the committee are broad and comprehensive, but the package, overall, is a solid, reliable family van, not a Cadillac. Expert testimony presented to the committee concluded that the actuarial value of the benefit package was almost exactly at the median of current employer-provided health insurance coverage (Testimony of Edwin C. Husted, Senior Vice President, Hay/Huggins Co., Senate Committee on Labor and Human Resources, February 4, 1994). Moreover, the committee provided a mechanism for the National Health Board to recommend modifications of the package to Congress if the program proved more expensive than anticipated.

Decisions of a board versus legislation. The committee was sympathetic to the view that the details of the benefit package should be considered by independent experts. The committee felt strongly, however, that the American people were entitled to know in advance what benefits were covered in a program approved by the Congress. Moreover, realistic cost estimates are impossible without a specific benefit package.

It is important to recognize, however, that the benefit package as enacted does not attempt to judge the necessity or appropriateness of particular medical procedures but instead lays down broad categories of coverage, such as hospital services and health professional services. Decisions on the necessity and appropriateness of particular procedures are made by individuals and their physi-

cians, subject to review for medical necessity by their health plan—just as they are today. Greater detail is provided for some categories of coverage, such as home health, where some limitations are placed on coverage, consistent with the need to keep the cost of the package reasonable and consistent with current insurance practice. More detail is also provided for preventive services.

The committee recognizes that there should be an opportunity for future modification of the benefit package, based on expert opinion, so the National Board is empowered to make recommendations to the Congress to modify the package. In the area of preventive health, expert judgements about the appropriate periodicity of services and desirable screening tests are changing particularly rapidly, so the Board is empowered to make changes in this area without Congressional approval.

New public obligations and the deficit. The vast bulk of the financing for universal health insurance coverage under the Health Security Act comes from the same sources it does today—private insurance premiums paid by individuals and businesses. The major new Government obligations under the program are the cost of discounts to businesses and individuals that cannot afford to pay the full cost of premiums on their own. In addition, the Government has assumed some new obligations for public health, for part of the cost of prescription drug coverage for Medicare enrollees, and for long-term home care and personal assistance services for senior citizens and younger Americans with disabilities.

Most of the additional costs of these Government obligations are paid for by savings in the current Medicare and Medicaid programs made possible by the comprehensive cost containment provisions of the Health Security Act. Overall preliminary estimates indicate that the net impact of the Health Security Act, as approved by the Committee, will be budget neutrality for the years 1995–2000 and that the program will achieve substantial long-term deficit reduction. If final estimates show that deficit neutrality has not been achieved, appropriate adjustments will be made in the legislation before it is considered on the Senate floor.

The committee concluded that the goal of universal coverage was sufficiently important to assume the additional Government obligations necessary for a workable program. In addition, the committee was aware that failure to adopt comprehensive health reform guaranteed a worsening Federal deficit as the result of the exploding cost of current health entitlement programs.

Committee views on specific provisions of the legislation are discussed below.

TITLE I

SUBTITLE A

Coverage of aliens

Sec. 1003(3). The bill as approved by the committee identifies individuals who are eligible to obtain the comprehensive benefits package through enrollment in a health plan under the Act. The committee stresses that the Act shall not be construed to prohibit the purchase of health insurance by persons who are not, by the

terms of the Act, eligible to obtain the comprehensive benefit package.

Children in State-supervised care

Sec. 1011 (e)(3)(F)(4)—It is the intent of the committee that children in State-supervised care, such as children in foster families, will receive State-funded medical coverage so foster parents will not be financially responsible for medical care provided to foster children in their home.

Sec. 1011 and 1012—The committee recognizes that children in state-supervised care, including those children under the responsibility of a public child welfare or juvenile services agency or a court, have an especially high incidence of developmental physical and emotional health problems. These problems are complex and require a broad range of physical, mental and supplemental services to help them overcome the effects of abuse and neglect. Children in state-supervised care need a portable health insurance plan that can accommodate their many changes in location and their need for ready access to health care specialists. It is important that these children not face barriers to receiving immediate and appropriate care, and continuity of care despite a change in providers.

The committee is concerned that tying a child's health care coverage to a foster family's health plan may be disruptive to children's continuity of care as reenrollment would be necessary with each new placement. There is also concern that if foster families are required to assume the health co-payments and deductibles for the child, this practice could prove a disincentive for individuals to participate as foster parents.

To address these concerns, the committee has directed that a child in state-supervised care be considered a family of one and enrolled by the State agency, which has legal responsibility for temporary or permanent custody for the child, in a fee for service plan. If the State agency has established a specifically designed health service delivery system to customize and more efficiently provide health services to children in State-supervised care, the State agency may enroll the child in the appropriate plan to accomplish this.

Children placed for adoption

Sec. 1011 (e)(3)(E)—It is the intent of the committee that this section does not include children placed for adoption under State supervision such as foster children.

SUBTITLE B—BENEFITS

Subpart B—Comprehensive Benefits Package

The committee believes that it is important to specify the benefits package to which eligible individuals would be entitled, including the cost sharing schedules, and specific exclusions from coverage. These aspects are essential to the Committee's intent to guarantee affordable, accessible care to all Americans, comparable to good private insurance coverage today. The committee intends that each health plan must provide directly or enter into such arrangements as may be necessary to ensure the provision of all items and services covered in the comprehensive benefit package to

eligible individuals enrolled in the plan when medically necessary or appropriate.

Health professional services

In section 1103, the committee intends that health services provided by health professionals legally authorized to provide such services in the State in which the services are provided would be covered if the services would have been covered if provided by a physician, either an M.D. or a D.O. By defining coverage as being for health professional services, rather than merely physician services, the committee intends to provide for coverage for the services of all nonphysician providers operating within their scope of practice.

The committee acknowledges the strong support of certain committee members and outside organizations for the specific inclusion of chiropractic health care services in the core guaranteed health benefits package relating to "health professional services". Although the committee has not specified in the bill which individual provider groups are eligible to perform covered health care services, it is the clear intent of the committee and the underlying bill that consumers shall have access to chiropractors and chiropractic health care services within the parameters of the guaranteed benefits package.

Furthermore, the committee acknowledges that in both actual medical practice and under the definition of "health professional services" contained in the President's benefits package plan and adopted in this bill, chiropractic health care services would be covered. Under the definition of "health professional services" proposed by the President and approved by the Committee, the services that a health professional is legally authorized to perform under State law would be covered, if those services would be deemed to be "physician services", when performed by a physician. Since chiropractors are licensed in every State to perform direct access, professional health care services, and since their services are considered the same or equivalent to "physician services", chiropractic care would be covered under the bill.

To further emphasize the linkage between chiropractic and "physician services" under the benefits package definitions in the bill, the committee notes that both doctors of chiropractic and medical doctors are licensed to perform an array of health care services including medical histories, physical examinations, diagnostic imaging (including x-rays), laboratory services, physiotherapy, nutritional and other counseling, postural analysis, and others. Therefore, because of the overlap in the scope of practices among chiropractors and medical physicians, the committee reiterates its position that the definition of "health care professional services" covers chiropractic health care services.

Finally, the committee notes that the special expertise and training of chiropractors is in the area of musculoskeletal and spinal mechanics and spinal manipulation techniques and services. At the same time, the committee is aware that while medical doctors perform a statistically small percentage of spinal manipulation services, medical doctors possess "plenary" licenses to perform services including spinal manipulation. Thus, under the assumptions con-

tained in the bill, any spinal manipulation services considered "physician services" when conducted by a medical doctor, would also be covered when performed by a chiropractor.

The committee expects the interpretations outlined under this heading regarding chiropractic health care services and the guaranteed benefits package established in the bill to be carefully applied in implementing the "health professionals service" provisions of the bill.

Emergency medical services for children

Because their physiological responses are different than those of adults, ill and injured children respond differently than adults in emergency situations. For example, their blood pressure may not indicate that they are in shock. Therefore, children need timely access to providers appropriately equipped and trained to provide pediatric emergency and critical care. Accordingly, the committee expects the Board to address these considerations when issuing regulations to interpret the section relating to emergency services.

Clinical preventive services

Sec. 1105 provides coverage of clinical preventive services, recognizing that insurance coverage of preventive services will help to increase their utilization and therefore to decrease the number of preventable diseases, and to improve and maintain health. The committee provides specificity regarding the services covered in order to help ensure equal application of services that are considered to be effective. The committee expects that the National Health Board to promulgate regulations, including periodicity schedules, to implement this section as described in section 1153.

Sec. 1105(a)(1) includes coverage of age-appropriate immunizations for the general population as recommended by the Advisory Committee on Immunization Practices (ACIP) in consultation with the American Academy of Pediatrics. The committee believes that, given the frequency of changes in the development of immunizations, it is important that the immunization schedule be based on recognized expert recommendations which are continually updated to account for new developments.

Age-appropriate immunizations include childhood vaccinations as well as those for adolescents and adults. Today, many vaccine preventable diseases occur among adolescents and adults. According to the 1994 *Guide for Adult Immunizations*, published by the American College of Physicians, as many as 70,000 adult Americans die each year from pneumococcal infection, influenza, and Hepatitis B. Given the strong evidence of vaccines' effectiveness, the committee believes that coverage of immunizations is vitally important.

Sec. 1105(a)(2) includes coverage for age appropriate tests and clinician visits. The committee expects the Board to issue regulations to implement this section, including the full scope of preventive clinician visits and tests for children provided according to established periodicity guidelines that are consistent with the most recent practice guidelines issued by the American Academy of Pediatrics in consultation with other expert groups.

Sec. 1105(a)(7) specifies coverage for mammogram screenings. The bill covers mammogram screenings every 2 years for women

age 40 to 49 in consultation with their physician, every year for women 50 to 64, and every 2 years for women 65 and over. The committee recognizes that breast cancer is the most common form of cancer for women in the United States and the leading cause of death in women between the ages of 15 and 54. In 1994 alone, over 182,000 new cases of breast cancer will be diagnosed and more than 46,000 women will die as a result of breast cancer. Approximately 20 percent of these new cases are in women under the age of 50.

Since 1987, the National Cancer Institute (NCI), has been advising women that breast cancer screening should begin by the age of 40 and consist of an annual clinical examination and a mammography screening performed at 1 to 2 year intervals to age 49. In late 1993, the NCI released a statement which reflected significant disagreement among the experts and differed with earlier recommendations for breast cancer screening. Despite the lack of agreement among experts about the role of routine screening from mammography for women ages 40 to 49, the NCI did conclude that women should discuss with their physicians appropriate health care regarding the early detection of breast cancer.

This change has sent confusing and conflicting messages to women age 40 to 49. In light of this confusion, it is critically important that women and their doctors decide what is the best course of care for the early detection of breast cancer including mammography screening. Currently, mammograms are the best existing detection mechanism. It is the intention of the committee to support research to improve other early detection techniques for younger women. For now, the committee believes that health plans must insure that women between the ages of 40 and 49 receive coverage for mammography screening that is appropriate for the early detection of breast cancer.

Section 1105(b) specifies that the comprehensive benefit package shall include any revisions to colorectal cancer screenings that are recommended by the U.S. Preventive Services Task Force in the periodic update of the Guide to Clinical Preventive Services planned for release in November 1994. The committee intends that the Board shall utilize any subsequent U.S. Preventive Services Task Force updates as its primary guidance in updating these clinical preventive services.

In addition, the Board has the authority under section 1153 to issue regulations establishing additional preventive services and periodicity schedules for high risk populations. Many Americans are exposed to preventable diseases on their jobs and in their workplaces, such as health care providers, day care personnel, police officers, teachers, emergency medical personnel, laboratory workers and veterinarians. The committee is also aware of the significant morbidity and mortality among Asian Americans resulting from preventable hepatitis B virus (HBV) infection. Prevention, early screening for HBV, and careful follow-up can prevent or delay the disease process among high risk groups. The committee intends the Board to retain flexibility to designate clinical preventive services for high risk populations based on appropriate public health standards where periodicity schedules are inadequate or medically inappropriate.

Clinician visit

The definition of clinician visit includes risk assessment and targeted health advice and counseling, including nutritional counseling. The committee intends that the risk assessment be appropriate for the age of the patient. For example, risk assessments for children may include appropriate child abuse screening and advice and counseling on injury and poison prevention. Risk assessments for adults may include appropriate screening for smoking, osteoporosis and domestic violence.

The committee does not intend by the definition of clinician visit in the preventive services section to preclude coverage of the same services for the medical management of a previously diagnosed individual under other categories of coverage. For example, once an individual is diagnosed as having diabetes, that individual would be covered for appropriate metabolic management and medical nutrition therapy as provided in other sections in this subpart, such as health professional services or outpatient diagnostic testing, when medically necessary or appropriate.

Mental illness and substance abuse services

For too long Americans with mental illness and substance abuse disorders have suffered from a lack of access to private insurance or inadequate insurance coverage. The very illness for which they needed care often disqualified them from coverage, and low yearly or lifetime limits impeded their continuity of care. The committee bill eliminates most artificial and arbitrary barriers and guarantees all Americans insurance coverage for these illnesses.

The committee's goal for the mental health and substance abuse benefit is to provide the broadest coverage possible with costs contained through high quality managed care. The committee intends coverage to be on par with other medical care to the extent possible, not withstanding the statutory limitation on some institutional care until 2001.

The committee flatly rejects the notion that the only way to contain costs in mental health and substance abuse treatment is through arbitrary limits on care. Arbitrary limits tend to lead to inappropriate utilization, hinder the flexibility needed to achieve cost-effective outcomes, and encourage people to delay seeking care, which drives up costs.

Rather, the committee is persuaded by the results of innovation in the private and public sectors showing that a well-managed, flexible benefit without arbitrary limits can serve more people more effectively at lower cost. The mental health and substance abuse benefit in the committee bill reflects this cutting-edge experience of Fortune 500 companies and innovative State systems.

The committee bill favors the provision of care in the least restrictive setting that is clinically appropriate by covering unlimited outpatient and intensive non-residential services. The committee believes this will encourage care in community-based settings, provide incentives for early intervention, and prevent unnecessary hospitalization.

Also unlimited is residential treatment for mental illness and substance abuse provided in therapeutic communities, halfway houses, and other "comparably inexpensive" facilities. The commit-

tee intends the standard for measuring "comparably inexpensive" care to be set by long-term residential substance abuse treatment facilities, which cost about \$50 per day. The committee does not intend the standards to be set by hospitalization or other costly inpatient and residential care.

The committee bill requires health plans to provide 34 days of hospital care for mental illness and substance abuse treatment. Individuals may trade 19 of those days for 76 days of residential treatment in a 4-for-1 substitution, but must retain 15 days as a safety net.

There are no lifetime benefit limits whatsoever. After January 1, 2001, all benefit day limits are lifted.

The committee intends that cost sharing for these services be on par with other medical services, not withstanding the differential for psychotherapy in high cost-sharing plans before 2001. The committee bill eliminates separate deductibles for these services and counts these expenses toward the annual out-of-pocket maximum. The committee affirmatively intends to provide Americans with catastrophic coverage for these services, as they have for other medical services.

The committee bill provides that, for the purposes of determining cost sharing, a "visit" for medications management is 1 week's worth of treatment. This means that the weekly cost of this service in low-cost sharing plans is \$10. The committee considers this \$10 to cover the visit to pick up the medication, the medication itself, and any tests or brief counseling needed to monitor the use of medication. The committee intends that pharmacotherapies for drug addiction (including methadone and other FDA-approved medications) be covered under this benefit.

The committee requires health plans to use quality managed care techniques to provide this benefit. The committee intends care decisions to be based on medical necessity and for managed care techniques to include central intake, preauthorization, and utilization review. The committee intends to enable health plans to deliver services in ways that would help contain costs but without compromising quality and access. Recognizing the philosophical and historical importance of consumer choice in American medicine, the committee bill also allows service delivery through fee-for-service arrangements.

The committee acknowledges evidence that, if used improperly, managed care techniques can act as a barrier to care in these areas. Consequently, the committee bill includes protections against abuses, which the committee expects responsible health plans and managed care firms can adopt without difficulty.

The committee bill requires treatment placement decisions to be based on medical necessity and uniform, publicly available assessment tools. The committee bill also prohibits review personnel from having financial conflicts of interest in their decisions, such as incentives for arbitrarily denying or reducing claims for care, even if the care is medically necessary.

Most importantly, the committee bill requires personnel who make and review treatment decisions to be State licensed, certified, or otherwise credentialed in the field in which they are making and reviewing decisions. By this, the committee intends that treatment

decisions and reviews be performed by clinically qualified professionals.

The committee does not intend for this to mean that review professionals must have credentials identical to treating professionals on any given case. But the committee does intend this to mean that a reviewer *must* be clinically qualified in the particular area of health care *and* the treatment being provided. For example, any qualified psychotherapist may review a psychiatrist performing psychotherapy, but medications management done by a psychiatrist would have to be reviewed by another psychiatrist. In addition, reviewers of substance abuse treatment would have to be qualified in the specific field of substance abuse and not just in the more general area of mental health.

Recognizing the unique needs of children with these illnesses, the committee bill establishes special delivery systems for them. The committee bill requires health plans to ensure that children with serious emotional disturbance or substance abuse disorders who are already involved with (or at imminent risk of involvement with) a public agency will receive their treatment through an organized system of care.

Systems of care have the capacity to involve multiple public agencies (including mental health, child welfare, education, and juvenile justice) to achieve coordinated delivery of an array of services. Through a system of care, children may also receive residential care in excess of the 76-day limit at State expense or through philanthropic resources, if the State determines additional care is clinically appropriate.

The purpose of an organized system of care is to ensure coordination among all parties involved in delivering and paying for services for a particular child. The level of coordination will vary, depending on the child's degree of involvement with the public system. In some cases, all that will be necessary is communication between a public program, such as special education, and a child's treating professional (including a health professional whose services are covered by the health plan and selected by the child or the child's legal guardian) to eliminate any overlap and ensure coordination of treatment goals. Other children, who are involved with several public agencies, may need a higher level of collaboration and cross-system planning.

A decade of experience has gone into the development of systems of care. In the last several years, foundations, states, and communities have invested significant resources in this approach, and in 1993 Congress enacted the Child Mental Health Services program to speed the development of these systems nationwide.

The committee intends to ensure that the progress made in developing systems of care is not lost and that gaps and duplication in services are eliminated as health care reform is implemented. The committee bill, therefore, requires health plans to establish linkages with any existing system of care. Where such systems do not yet exist, the committee requires health plans to participate, and if necessary to lead, in the development of collaborative arrangements.

Family planning services and services for pregnant women

The category "family planning services" covers voluntary comprehensive family planning services including counseling, education, contraceptive drugs and devices (subject to approval by the Secretary under the Federal Food, Drug and Cosmetic Act), sterilization services and medical care to diagnose and treat infertility (other than exclusions in section 1141(b)(5)). Coverage for "services for pregnant women" includes prenatal care, maternity care, treatment for pregnancy complications, post-partum care, termination of pregnancy and other medical services for pregnancy.

It is the committee's view that nothing in this act conflicts with constitutionally permissible State laws or regulations that restrict the performance of post-viability abortions or that prohibit the performance of abortion absent parental consent or notification, waiting periods, or informed consent. It is the committee's intent that this act does preempt State laws that prohibit, restrict or place conditions on insurance coverage of abortion.

Outpatient prescription drugs and biologicals

Sec. 1113 of the bill provides for coverage of outpatient prescription drugs and biologicals. Subsection (3) describes coverage of medical foods for people with inborn errors of metabolism. Medical foods are special diets commercially manufactured for consumption only by persons with inborn errors of metabolism whose bodies inadequately metabolize protein and or specific amino acids. These conditions are rare. Phenylketonuria, the most common, affects 150-200 newly born infants in the United States each year. The other diseases are even less common, affecting about 100 newborns each year. Inborn errors of metabolism begin at birth and, if not promptly treated with special diet, produce severe mental retardation or even death in some cases. For the child or adult with one of these conditions, the availability of medical foods can mean the difference between severe mental retardation or another serious condition and leading a life without significant mental or physical impairments. Untreated patients may be candidates for institutionalization, or medical, or other governmental social assistance. With medical dietary treatment, most patients can lead lives without significant mental or physical impairments with careful supervision by appropriate health care professionals.

The bill also clarifies that accessories and supplies that are used directly with drugs and biologics to achieve the therapeutic benefit of such drugs or biologics will be covered. Examples of such accessories and supplies would be disposable syringes used in connection with insulin and other medications, and blood glucose monitoring equipment.

Outpatient rehabilitation services

Sec. 1114 of the bill provides for coverage of outpatient rehabilitation services. Subsection (a) describes the range of outpatient services covered under this benefit, including occupational therapy, physical therapy, respiratory therapy, and speech-language pathology services and audiology services. Subsection (b) sets out limitations on such coverage.

The section begins with a list of covered services. This list is intended to describe a range of services provided by qualified rehabilitation health professionals. For example, outpatient rehabilitation services specified in the bill include orientation and mobility and rehabilitation training, which are designed to restore functional capacity or minimize limitations resulting from blindness or visual impairment.

By using the phrase "as a result of an illness, injury, disorder or other health condition", the committee intends that outpatient rehabilitation services be made available to all persons who would benefit from such services to restore or maintain functional capacity or minimize limitations on physical and cognitive functions. The words "disorder or other health condition" are intended to include individuals with congenital conditions or other disabilities. This language assures that individuals with the same presenting characteristics and need for therapeutic intervention will have the same right to services. For instance, an infant born with cerebral palsy will have the same coverage for physical therapy and occupational therapy as an infant who develops meningitis shortly after delivery resulting in cerebral palsy. Both children have the same condition and require the same medical interventions. Under the bill, both children will have the same coverage.

Children, particularly while they are in the process of attaining developmental milestones, typically require therapies to minimize limitations in physical and cognitive functions, including attaining new functional abilities at an age-appropriate rate. This type of therapy should be provided by a qualified rehabilitation health professional. Without timely and effective services, children would fail to attain essential physical and cognitive functional skills and would incur unnecessary lifelong impairments as a result. For instance, services designed to minimize limitations would include those to assist children with cerebral palsy or Down syndrome to properly hold up their heads or to learn to crawl. A young person with spina bifida may need therapy to improve fine and gross motor skills which are necessary to perform bowel and bladder care, an essential component of health and functioning.

A similar situation may occur with an adult who has profound mental retardation and related physical impairments. Because of changes in the individual's overall condition, that individual may need therapy to address muscle contractures, to improve fine motor skills necessary for self-care, or to address a newly emerging aspect of their disability; or to avert physical or cognitive impairments that would be likely to develop in the absence of adequate outpatient rehabilitation services.

Durable medical equipment, prosthetic devices, orthotics and prosthetics

Sec. 1115 of the bill provides for coverage of durable medical equipment, prosthetic devices, orthotics and prosthetics. By incorporating by reference the definition of durable medical equipment in the Social Security Act, the committee does not intend to limit durable medical equipment to the meaning given the term when that statute was written. The Health Care Financing administration has periodically revised its durable medical equipment policies

under the Social Security Act, and the term is evolving from one that describes equipment used primarily in the home to one that describes equipment that can be used in a variety of settings in the home and in the community. The committee expects that this evolution will continue as people in need of durable medical equipment have greater choices and access to ever-improving technologies.

Nothing in this section should be construed to prevent an individual from purchasing equipment or services that are more expensive than equipment or services that are determined to be medically necessary or appropriate for that individual. The committee intends that an individual would be allowed to purchase or rent the more expensive equipment or services by paying the difference between the cost of such equipment or services and the cost of equipment or services determined to be medically necessary or appropriate for that individual. The supplier, in turn, would bill and receive payment directly from the health plan for the cost of the medically necessary or appropriate equipment or services.

The committee encourages the Board to use contemporary standards for what constitutes durable medical equipment. The committee also believes that it is critical that the Board, health plans, and others involved in coverage for durable medical equipment incorporate practices that protect against fraud, waste, and abuse. Enrollees should be provided ready access to equipment that is medically necessary or appropriate, but vigorous steps should be taken to minimize the potential for fraud, waste and abuse in the provision of this benefit.

In describing prosthetic devices, the bill states that such devices replace all or part of the function of an internal body organ. The committee believes that a functional approach is appropriate. The term "function" is significant in that it recognizes that medical and assistive technologies can often restore or provide for bodily functions more effectively through the use of physically attached or externally activated devices than through replacement of the body organ itself. For example an augmentative communication device, which can replace the function of speech for individuals who have lost or do not otherwise have the ability to communicate orally, may be a more effective means, or the only feasible means, of attaining speech as compared with replacing an individual's larynx.

Although the bill limits coverage of eyeglasses, contact lenses, and hearing aids to individuals up to age 18, the committee does not intend to exclude coverage for individuals 18 or older for other appropriate covered prosthetic devices covered in this section that are used to replace all or part of the function of a body organ used in the functions of vision or hearing.

The bill also provides for coverage of appropriate accessories or supplies used directly with covered equipment or devices to achieve the therapeutic benefits of such equipment or devices or to assure the proper functioning of such equipment or device. An example of such an accessory would be an environmental control unit which can be used by an individual with quadriplegia to activate the tilt or raise functions of a hospital bed so that the individual can reposition himself or herself.

Hearing aids for children and hearing care

Sec. 1117 of the bill provides for coverage of hearing aids for children when recommended by a physician or an audiologist. The critical years in which speech and language develop are birth through age 6. For a child who needs hearing aids, and does not have them, this speech and language acquisition window of opportunity is lost. The committee has provided for coverage of hearing aids for children to ensure that they are able to acquire language and related cognitive abilities to their full potential. In using the language "when recommended by a physician or an audiologist", the committee does not intend to express an opinion regarding the appropriateness of one provider or another in dispensing hearing aids to children.

Additional benefits related to hearing loss are covered under clinical preventive services (hearing screening as part of scheduled clinician visits) and outpatient rehabilitation services (diagnostic and rehabilitative audiology services and speech-language pathology services).

Investigational treatments

Sec. 1119—In an age of rapidly changing technology, treatments that are experimental one day may become accepted medical treatment the next. Some health plans have not kept pace with changes in this area of medical practice. This has led to disputes between patients, providers and health plans. Surveys conducted by the General Accounting Office and the New England Journal of Medicine have found wide variations in coverage for investigational treatments both across health plans and within the same health plan. While coverage of investigational treatments may continue to be a difficult area, the committee intends to clarify coverage of investigational treatments and the patient care associated with such treatments in the comprehensive benefit package.

This section specifies that an item or service described in the benefit package is covered (subject to exclusions, limitations, and cost sharing described in this title), when it is provided to an individual in the course of an investigational treatment if the item or service is required to provide patient care pursuant to the design of a qualifying investigational treatment and if the item of service would not normally be covered as a clinical trial by another payor. Services normally paid for by other sources, such as the cost of the investigational agent or device itself, may be paid for at the discretion of the health plan so long as the plan makes a determination based on objective protocols applied consistently to all enrollees.

Extra-contractual services

Plans may provide coverage to enrolled individuals for extra-contractual items or services (such as medically appropriate alternative items or services that are not covered) if the plan determines such services to be appropriate and cost effective and if such items or services are acceptable to the individual or family. The committee intends for the extra-contractual services provision to provide for flexibility in cases where a plan and an enrollee determine that it is in their interest to provide items and services outside the scope of the basic benefits package. Private health plans

currently offer such items and services in cases where they find it cost-effective. Plans often refer to this practice as "large case management," and use it as an opportunity to assist individuals and families in coordinating services for children and adults with significant medical involvement.

One example of an extra-contractual service would be paying for a house to be retrofitted so that the person can leave the hospital and receive care in a more cost-effective manner at home. Similarly, a plan may decide to provide medical foods not covered under the outpatient prescription drug and biological benefit that would have a significant impact on the containment of costs in the treatment of HIV/AIDS, cancer, and other diseases. A third example of extracontractual services could be if the health plan and the individual enrollee determine that a nursing home is capable of providing quality subacute care and where such treatment could be an appropriate cost-effective alternative to treatment in an acute care hospital and provide a continuum of care between hospital care and home care.

Medically necessary or appropriate

The committee intends that the National Health Board may promulgate such regulations or establish such guidelines as may be necessary to interpret the benefits package, including regulations or guidelines as may be necessary to provide national consistency and to interpret sections relating to the exclusion of certain services that are not medically necessary or appropriate. When issuing such regulations or guidelines, the committee intends that the National Health Board shall consider: (1) any relevant determinations by the Food and Drug administration with respect to safety and effectiveness, (2) any practice guidelines that have been developed or certified under section 912 of the Public Health Service Act, (3) published peer-reviewed medical literature, (4) opinions of medical specialty groups and (5) evidence of general acceptance in the medical community.

The committee recognizes that decisions regarding medical necessity or appropriateness of care are first addressed by the health provider and the individual enrollee, subject to review by the health plan.

The committee intends that any determinations of the medical necessity or appropriateness of a covered service or item for an individual under age 21 shall be consistent with the factors that enter into clinical judgments on behalf of individuals in that age group. These factors include but are not limited to healthy growth and development of an individual patient. By development, the committee means the maturing of an individual's physical, emotional and intellectual capacities from birth to adulthood.

Duty to disclose incorrect test results

This section is intended to ensure that patients are notified promptly by their health care provider of any test errors that may affect that patient's diagnosis or treatment. This includes notifying the patient of the existence and nature of the error, the corrected result, and the new diagnosis or recommended treatment, if any.

It is the intent of the committee that the Secretary should issue proposed regulations as soon as possible so that interested parties can comment and so that workable rules will be in place by the time specified by the act.

The committee does not intend for this section to preempt stricter State laws; rather, State laws that are more protective of the patient are permissible under this section.

SUBTITLE C—STATE RESPONSIBILITIES

Sec. 1203—It is the committee's view that this section authorizes States to take necessary steps to carry out their duties to safeguard underserved and vulnerable populations. The bill permits a State to provide health plans with enhanced risk adjustments or other financial incentives where such measures would help meet the State's obligation to ensure that health plans enroll, without discrimination, members of disadvantaged groups, such as low-income people, people of color and people with disabilities, and populations with health status (including anticipated need for care) that makes them vulnerable to discrimination. Without such provisions, health plans may have an incentive to engage in practices that deny equal access to care to such populations.

In many rural and other underserved areas (including many inner cities), consumers often cannot find providers. Furnishing health insurance will not be enough to assure adequate access to care in such rural and other underserved areas unless infrastructure problems are also addressed. The bill accordingly permits a State to adjust payments or provide other financial incentives to fulfill its duty to ensure that plans are available to eligible individuals, in each portion of a health coverage area, with adequate access to a choice of community-rated health plans providing services with reasonable proximity to the residence of the individual, including (to the maximum extent practicable) adequate access to a plan whose premium is at or below the weighted average premium for plans in the health care coverage area. In addition to measures encouraging existing health plans to expand into underserved areas, a State may take steps to promote the development of new health plans in such areas.

Sec. 1205—Consumer Information and Marketing. It is the committee's view that adequate State oversight and protection in the areas of consumer information and health plan marketing are crucial to the effective operation of this Act. Consumers must have access to a sufficient amount of information in order to make educated choices among health plans. Moreover, health plans must be marketed to all consumers in an area so that every family has equal access to each plan sold in the area and so that competition based on avoiding individuals that may be sick—a major problem in our existing health care system—can be eliminated.

Under this section, States must ensure that consumers have access to key pieces of information including the following: (1) comparative plan reports that contain information on plan prices, providers and institutions available under the plan and any restrictions on access to providers or services that plan may impose; (2) summary plan descriptions for each plan that provide more detailed information about the terms of the plan, and; (3) health plan

performance reports designed by the National Quality Council that will provide detailed information about each plan's performance across the range of national quality measures.

Under subtitle F, health plans are also responsible for making available to enrollees and potential enrollees other important pieces of information that consumers will need to make informed choices among health plans and to exercise their right under the act. This information includes disclosure of utilization management protocols and financial incentive plans used in plans' arrangement with their providers, information about centers of excellence to which enrollees may be referred in certain cases and information about participating providers. Other provisions of the act require plans to prepare and file financial reports and additional information about the plan. It is the committee's intent that States shall assure the availability of this information to consumers consistent with the state's general oversight responsibility for health plan compliance with the plan requirements detailed in the bill.

State responsibilities re: worksite health promotion

Sec. 1206—The committee intends for the wellness program administered by the State to include the following components:

(1) Certification—The state, through a designated agency, will collect from employers worksite health promotion program applications developed by the Secretary. These forms shall provide for a means of employer self-certification of eligibility for discounts offered by health plans.

(2) Compliance—The designated State agency shall develop a plan for monitoring the qualified worksite health promotion program offered by employers to ensure that these programs are in compliance with the guideline established by the Secretary. In developing such a plan, the States shall establish requirements pertaining to employer documentation of the employer's worksite health promotion program. Determination of compliance shall be based on, but not limited to, such documentation.

The committee bill does not provide special incentives to large group purchasers to offer wellness programs since these purchasers are presumed to enjoy an inherent benefit from such programs in so far as such programs hold down experienced-rated and self-insured premiums. The committee recognizes, however, the benefit of the program offered by large group purchasers.

Consumer advocate

Sec. 1207—The bill establishes a National Center of Consumer Advocacy and an office of the consumer advocate in each state. The consumer advocate is modeled on existing programs, such as the long term care ombudsperson, that have demonstrated that an independent consumer advocate can be a crucial link in assuring the provision of services to all individuals, including the most vulnerable and historically underserved. The consumer advocate serves a valuable function by informing consumer about their rights and responsibilities under this act and assisting them in dealing with problems that may arise.

The offices of consumer advocacy will assist consumers in evaluating and enrolling in health plans, applying for premium and cost

sharing discounts, receiving services and benefits, and resolving disputes with providers or plans. In addition, the consumer advocate is important to provide a voice on behalf of consumers in considering and recommending additional health care reforms to Federal and State legislators. The creation of a strong consumer advocate system is a crucial aspect of health care reform.

Coordinated health care services for children

Sec. 1209—It is the intent of the committee that each State designate a lead agency to assure ongoing access and coordination of care for children with special health care needs. It is the intent of the committee that State agencies supply technical assistance to the state, other agencies, health plans, and providers to make recommendations on assuring access for children to medically appropriate medical providers, services, and specialty networks. The agency is directed to coordinate with other State agencies providing services to children and their families to facilitate the optimal delivery of services to eligible children. These other agencies include the State Medicaid plan, title V programs, programs under the Developmental Disabilities Act and Bill of Rights, the Individuals with Disabilities Education Act, and other Federal or State programs that provide services or targeted assistance to children with special health care needs, including other programs of this act. The committee intends that the lead agency furnish the State with specific and aggregate data to provide the State with information relevant to the certification and recertification of health plans.

Utilization review

Sec. 1210—Many health plans have instituted utilization review or utilization management programs in an effort to control costs. These programs have used methods ranging from requiring preauthorization and second opinions on particular cases, to more comprehensive reviews of practice standards and overall performance by health caregivers.

Recent studies by the General Accounting Office confirm that the application of utilization review guidelines by payors under Medicare are significantly inconsistent. GAO further found that the utilization review programs studied did not provide adequate training for reviewers and that there was no systematic evaluation of either the protocols being used or their application.

It is the intent of the committee that section 1210, which establishes Federal standards for utilization management programs and State responsibilities for such programs, requires utilization management programs to meet certain standards for certification. Health plans cannot employ or contract with a utilization management organization whose conditions of employment or contract terms include reducing or limiting medically necessary or appropriate services provided to plan enrollees.

Furthermore, to the extent that individual case by case review continues to be used, this section requires that programs disclose the protocols used for making clinical decisions to approve or deny a claim, and that the protocols reflect current medical practice and are applied consistently by the program's reviewers. If reviewers are unavailable, the section requires that programs shall make

other arrangement for providing needed care, or the care shall be considered authorized.

Section 1671(d), which establishes the responsibilities of the Department of Health and Human Services for developing standards for utilization management programs, calls upon the Secretary to consult with appropriate organizations and promulgate uniform Federal standards. Since States are empowered and required to ensure compliance with the Federal standards, it is the committee's view that States should be consulted in the development of these standards.

Oversight of health plan enrollment activities

Sec. 1212—Under the committee's bill, most working families will enroll in a health plan through their employer or through a co-operative chosen by the family's employer. Families that work for large employers and select coverage from such employers will enroll through the workplace as they do today. Other enrollment options are available to families that are not connected to the work force and to families that exercise enrollment elections under section 1303. It is the committee's view that in discharging its responsibility to assure that each community-rated individual is enrolled in a health plan of the individual's choice, a State is authorized to take a range of appropriate measures under the bill. Such full enrollment is a critical element of universal coverage. Not only is full enrollment essential to protect health, it is needed to prevent cost-shifting. Accordingly, culturally competent and language-appropriate information should be widely distributed to inform individuals and families of the alternatives for health coverage and the process for enrollment.

The committee intends for the States, in the oversight of health plan enrollment activities, to assure plan compliance with the enrollment requirements of this act. In particular, the committee intends for States to:

(1) Actively monitor plan enrollment activities to assure plan compliance with section 1516, including provisions of section 1516 that require plans to accept the enrollment of each eligible individual, and the other enrollment requirements provided for in this act and in regulations to be promulgated by the Board;

(2) Establish appropriate guidelines and mechanisms to assure that plans enroll individuals in a manner that guarantees each individual a fair chance of enrollment in plans with limited capacity, regardless of the method by which an individual seeks enrollment in the plan or when an individual seeks such enrollment, so long as the application is made during the designated open enrollment period; and

(3) Review enrollment and disenrollment from health plans consistent with their responsibilities under section 1504.

The committee further intends that a state, in carrying out its responsibilities under subsection (b) (regarding point of service enrollment for uninsured individuals), should devise mechanisms for enrolling an individual who has not yet enrolled in a health plan when such an individual seeks care. A State may provide interim coverage during a reasonable period of at least thirty days during

which the individual receives notice of enrollment options and can make a choice of plan.

When an individual is assigned to a health plan because of failure to take advantage of a reasonable opportunity to choose a plan, such assignment should take into account, to the extent reasonably ascertainable by the state, the individual's circumstances, including area of residence, health needs and income. An amount equal to twice the family share of premiums otherwise applicable shall be charged, except where the individual shows, in a fair hearing provided by the State upon proper notice, good cause for failure to enroll in substantially timely manner. Such good cause could include, for example, failure to receive notice; failure to understand features of the enrollment process based on limited literacy, failure to comprehend the language of notices, or developmental or mental disability; physical or transportation barriers to enrollment; severe illness or significant family problems; absence from the State of residence during relevant enrollment periods; belief that coverage was already being furnished through another family member or otherwise; belief that the individual was not eligible for coverage; and significant delays or errors by application or enrollment offices. Repayment of excess amounts would be addressed in a fashion comparable to repayment of excess subsidies in reconciliation described in section 6204(e).

Sec. 1213—Administrative Allowance Percentage. it is the Committee's view that an important feature of the committee bill is the set-aside of an administrative allowance to support the activities of the states and the national and State consumer advocate functions. Health care reform will require a new level of responsibility by the states, one that the committee wants to ensure states are able to meet. Although regulation of insurance and public health historically have been State responsibilities, the states have varied widely in the amount of resources dedicated to these areas. Recognizing the importance of our health care system, the bill ensures that each State will have sufficient funding to ensure that all State residents have health insurance coverage and to oversee health plans and providers.

State single-payer option

Sec. 1221–1224—The committee intends, through the single-payer provisions of this act, to provide to states the flexibility to implement a State single payer system in a manner that is consistent with other key features of the bill including those that provide for universal coverage, comprehensive benefits, cost containment and shared responsibility between individuals and employers. Under a single payer system the State or its designated administrator would pay health care practitioners directly for their services, rather than providing care through health plans.

Under the single payer provisions of this act, applications to establish a single-payer State would be filed with the Board. It is the intention of the committee that States could extend a single-payer system to most residents of the State upon approval of the application by the Board. A Federal waiver would be required, however, for a State to fold the Medicare population into its single-payer system.

Sec. 1238—The committee intends that if an individual or family fails to pay amounts owed under this title, coverage and services would not be delayed, denied, reduced or interrupted. Providers would receive full reimbursement from health plans for furnishing care, without regard to whether premiums have been paid, and recourse would be against the individual or family responsible for such failure to pay. Although no individual or family may be denied care for failure to pay premiums or cost-sharing amounts in advance, such individual or family would be responsible for paying such obligations after care has been furnished, just as under current law. Failure to provide care based on nonpayment of amounts owed under this title would be subject to the same remedies as other discrimination prohibited under this act.

Application process for cost sharing reductions and premium discounts

Sec. 1282.—This section specifics the application process for cost sharing reductions and premium discounts based on income. The Board will promulgate regulations for States to process these applications. In acting on applications with reasonable promptness, providing notice and fair hearings for adverse actions (such as delays and complete or partial denials), conducting effective and appropriate outreach for applications from eligible families, coordinating with other means-tested public assistance programs, and furnishing necessary and appropriate assistance in completing and filing applications and income reconciliation statements, States must comply with standards set by the Board.

End of year reconciliation

Sec. 1283—Rules promulgated by the Board governing repayment of excessive subsidies should permit low-income families to elect repayment through periodic payments that would be limited based on ability to pay.

SUBTITLE D—CONSUMER PURCHASING COOPERATIVES

Special rules for FEHBP supplemental plans

Section 1322—Section 1322 is intended by the committee to ensure that individuals enrolled in FEHBP plans have the same access in supplemental policies as employees in the private sector generally. The committee anticipates that supplemental benefit policies and cost-sharing policies will be available to provide sector employees and that private sector employees will be able to negotiate with their employers for employer contributions to the cost of such policies. The inclusion of section 1322 equalizes the treatment of Federal employees by (1) ensuring that supplemental policies will also be available to Federal employees and annuitants, and (2) providing a mechanism for representatives of Federal employees to meet and confer with their employer—in this case the Federal Government—over both the content of the supplemental benefit policies to be offered and any premium contributions to be made by the Federal Government on behalf of Federal employees and annuitants. (The National Partnership Council, which has successfully dealt with other labor-management issues in the Federal sector,

will determine the process.) This section further makes clear that supplemental policies made available by FEHB plans will be available to any individual enrolled in an FEHB plan, whether a Federal employee or not, in the same way that supplemental policies offered by any plan in the community-rated pool are available to any individual enrolled in that plan.

SUBTITLE F—HEALTH PLANS

Prohibition of discrimination

Section 1509(1)(B), which prohibits discrimination on the basis of a provider's status as a member of a health care profession, is intended to assure appropriate utilization of nonphysician health professionals. Utilization of such professionals is particularly important in rural and other areas where shortages of health professionals are common. By preventing discrimination against qualified health care professionals, the committee intends to ensure that consumers have a choice of a variety of qualified health professionals and expanded access to necessary primary and specialty care.

Section 1509(b)—The committee believes that it is appropriate for health plans to reimburse equally providers who are performing identical medical or surgical procedures and who have equivalent training, regardless of their specific academic

Community rating

Section 1511—The committee intends for the Secretary to promulgate regulations under this section that allows plans to make adjustments in the community rate offered to enrollees, but only on the basis of age and only within a band that limits such variation to a specified percentage. This variation would be allowed only during the transition to universal coverage, terminating on the date specified in this act. After such date, the committee intends for the regulations promulgated by the Secretary to provide for pure community rating, with variations allowed only by premium class and health care coverage area. The Board has the authority to recommend to the Congress that a form of modified community rating remain in place if it determines that there will be large increases in premiums for a sizable portion of the population under pure community rating.

Access to care

Section 1514—The committee intends that providers must be fully compensated for reduction in cost-sharing to avoid harming providers accepting disproportionate numbers of low-income patients, to prevent cost-shifting and to encourage providers to treat such patients.

Section 1514(a)—Section 1502(f)(2) of the bill requires low cost sharing plans to offer enrollees the opportunity to obtain coverage for out-of-network items and services by a health care provider who is not a member of a provider network of the plan. The out-of-network option can be critical for individuals with complex diseases, disorders, or other health conditions, and it may be exercised at the sole discretion of the enrollee. The committee does not intend that

a medically necessary item or service be denied reimbursement when provided by an out-of-network provider due to the availability of the same item or service from a provider within the network.

Enrollment

Section 1516—The committee intends for States, in their fulfillment of their responsibilities with respect to plan capacity limitations, to provide for mechanisms whereby individuals are enrolled in plans with limited capacity consistent with the following priorities. Families already enrolled in the plan are to be given priority in continuing their enrollment. Other individuals who seek enrollment during the open enrollment period would each receive an equal chance of enrollment, through a random assignment process or some other verifiable means that would guard against the ability of a health plan to effect a targeted enrollment of low-risk populations. To the extent practicable, such methods prescribed by the Board shall allow families the opportunity to designate a second enrollment preference and enroll in such plan in the event that enrollment in a preferred plan is unavailable due to capacity limitations.

Section 1523—The bill includes a number of provisions to ensure that individuals have appropriate access to specialists in all plans (fee-for-service or network plans). Section 1523 provides that each health plan, in order to become certified and remain certified, must enter into agreements or arrangements with an appropriate mix, number, and distribution of qualified health professionals to ensure the provision of all services covered by the comprehensive benefits package to eligible individuals enrolled in the plan.

The committee intends that section 1523(c), listing requirements for network plans, would apply to all health plans that are not fee-for-service arrangements. The committee intends the provisions to ensure access on the part of consumers who require the services of health professionals with specialty training or experience. The comprehensive benefits package detailed in this Title will not meet the needs of consumers requiring specialty care if they are not able to access such care as a result of inappropriate barriers posed by gatekeepers or an inadequate mix, number, or distribution of network participants.

The committee believes that section 1523(c)(2), addressing the issue of when gatekeepers must have specialty training or experience, addresses a critical need for individuals with significant ongoing health care needs as a result of mental or physical disability or chronic condition. For example, in some circumstances it may be appropriate for a specialist in physical medicine and rehabilitation to serve as a gatekeeper for a person with a spinal cord injury, head injury, or stroke. A specialist in neurology may be appropriate to manage the care of a person with epilepsy, multiple sclerosis, or Alzheimer's disease. Some children may appropriately be served by a pediatric specialist in the gatekeeper role.

Section 1523(c)(2) permits plans to use either a specialist or a care coordinator from an interdisciplinary team. To the extent that an individual's needs are appropriately met by an interdisciplinary team, the committee encourages the plan to consider providing an individualized comprehensive assessment to such individual. The

comprehensive assessment should be performed by one or more qualified health professionals, and should identify all of the medically necessary or appropriate health related services that are expected to be needed that are within the guaranteed benefit package. As health needs change, the individualized comprehensive assessment should be modified to reflect these changes.

The committee recognizes that a specialist is often the main or primary physician in terms of personal contact and management for people with disabilities and chronic health conditions. In these circumstances, the specialist is often the best informed and most competent manager of resources and services for these individuals. Without an appropriate gatekeeper, many individuals will be at risk of improper or delayed treatment, misdiagnosis, and, in some instances, premature death.

Section 1523(c)(3), addressing the issue of continued care for patient-enrollees with chronic diseases, disorders, or health conditions, fulfills a similar role to section 1523(c)(2). Just as it is appropriate for gatekeepers to be specialists in some circumstances, it is also appropriate for patients with a long-standing relationship with a specialist to be able to maintain that relationship without gatekeeper approval in some circumstances. For example, an adult woman with Spinal Muscular Atrophy with respiratory complications may have a longstanding relationship with a respiratory specialist who has successfully treated and monitored her respiratory condition for several years.

The bill requires in section 1523(c)(4) that all network plans must provide access to eligible centers of specialized treatment expertise either through written provider participation agreements or through reimbursement at the plan's normal rates. Many hospitals and health plans are not equipped to provide specific specialized services. The committee intends that plans have sufficient arrangements across all conditions and all areas, e.g., cardiac, pulmonary, gastroenterology, oncology. The committee recognizes that specialized treatment expertise exists in many settings throughout the nation, including academic health centers and teaching hospitals and other centers of advanced care not affiliated with academic institutions. Examples of these centers of advanced care not affiliated with academic institutions. Examples of these centers of advanced care include cancer centers, pediatric care facilities, and centers providing specialized treatment in the areas of pain management, traumatic injury, specialized orthotic and prosthetic care for amputees and other individuals with disabilities. The committee recognizes that centers of advanced care, whether affiliated with academic institutions or freestanding centers, may become eligible centers under this subsection by meeting the strict objective criteria established by the Secretary.

Section 1523(e)—The committee intends for a plan described in subsection (e) of this section to include a plan that reimburses providers in accordance with the point-of-service provisions of this act.

Health plan arrangements with providers: Regarding children

The committee recognizes that children have diagnoses, courses of treatment and developmental needs that are different from adults. It is the committee's intent that plan requirements for pro-

vider agreements with an appropriate mix, number, and distribution of qualified health professionals shall include sufficient agreements with primary and specialty pediatric providers for children. Such providers include pediatricians and pediatric specialists, family practice physicians, hospitals with pediatric services, children's hospitals, and children's long term care and rehabilitation facilities.

The committee intends that all plans shall provide specialized medical services to children as medically necessary or appropriate and consistent with standards of pediatric practice, including age-appropriate specialty care.

For children with complex medical conditions or special health care needs, health plans must assure age-appropriate specialized services consistent with the benefits included under title I of this act. All health plans will provide enrolled children access to centers of specialized treatment expertise in pediatric specialties for physical and mental health conditions.

The committee intends that such pediatric specialists may be used as gatekeepers when a child's level of medical complexity or chronicity make it appropriate. In addition, the committee intends that children with chronic medical conditions who receive their care through a pediatrician or family practice physician gatekeeper may receive specialty care for that condition without seeking repeated prior gatekeeper approval.

The committee intends that children receive timely access to medical providers appropriately equipped and trained to provide pediatric emergency and critical care. The committee directs the Secretary to require standards and mechanisms to ensure that all ambulance and prehospital personnel reimbursed under this act provide appropriate emergency medical services for children, and that all hospitals and nonhospital emergency care centers reimbursed under this act either provide appropriate pediatric emergency care or have in place protocols and procedures for transferring children to facilities that are capable of providing such care when necessary.

Direct billing

Section 1523(f)(2)—Subparagraph (B) prohibits any person or entity performing ancillary health services from presenting a bill for the service to any person other than the individual receiving those services in order to reduce incentives for ordering unnecessary tests or where payment is made for a bundle of services. The committee intends that the Secretary shall, in regulations, establish a list of exceptions to this subsection. These exemptions should be limited to situations in which there is little or no incentive for increasing the charge or ordering unnecessary tests or in cases where an individual receiving such services requests in writing that the bill be directed to someone other than the individual receiving the service, or the health plan of the individual. The committee intends that the exception process established under these regulations is consistent with and in compliance with all other provisions of this act, including the data and privacy requirements in title V.

Examples of other individuals or entities that may be billed under certain circumstances as specified in regulations may include:

(1) an immediate family member of the recipient of the services or any other person legally responsible for the debts or care of the recipients of the services;

(2) a third-party payor designated by the recipient of the services;

(3) a hospital or skilled nursing facility where the recipient of the services was an inpatient or outpatient at the time the services were provided;

(4) a clinical laboratory independent of a physician's office that has referred work to another independent of a physician's office that has referred work to another independent clinical laboratory; and

(5) other individuals or entities identified by the Secretary in regulations.

Health security cards

Section 1524—Under this section, health plans are responsible for issuing health security cards to each plan enrollee consistent with standards for such cards developed by the Board. The committee intends that all Medicaid beneficiaries and recipients of low-income subsidies under this act would receive a health security card for their health plan that is identical in appearance to that provided to those with employer-sponsored insurance.

Utilization management protocols and physician incentive plans

Section 1525(b)—Health plans have devised a variety of mechanisms to oversee or limit provider treatment decisions in order to control costs. Some mechanisms have had important positive effects on health care delivery. In many cases, more care is not better or more effective health care. Unfortunately, some of the mechanisms devised have directly or indirectly had the effect of reducing care for financial reasons, not medical appropriateness. Studies repeatedly have shown that the most successful types of medical oversight are systems in which providers are part of a collaborative review process or where providers are reviewed with or by their peers on patterns of medical treatment. The committee believes that health plans should work with providers to improve their medical practices rather than to simply shift financial risk onto providers or use monetary incentives to alter provider practices.

The bill contains a number of protections for patients and providers to assure the provision of medically necessary or appropriate care. Section 1525 requires all health plans to disclose to enrollees and potential enrollees the utilization review protocols and financial arrangements used by a plan.

It is the intention of the committee that utilization management personnel be qualified to review the particular treatment they are reviewing. In addition, the committee is aware that standards both for licensing health professionals and for accrediting utilization management personnel vary widely among states. It is not the intent of the committee that section 1525(b) require that utilization management personnel be licensed, certified or otherwise credentialed in the same State where the treatment is to be delivered. However, until Federal regulations are established regarding utilization management programs, the committee recommends fur-

ther study to determine how review personnel should best be trained to respond to variations in health professional practice standards in different states. The committee bill requires personnel who make and review treatment decisions to be State licensed in the field in which they are making and reviewing decisions. By this, the committee intends that treatment decisions and reviews be performed by clinically qualified professionals. The committee does not intend for this to mean that review professionals must have credentials identical to treating professionals on any given case. But the committee does intend this to mean that a reviewer must be clinically qualified in the particular area of health care and the treatment being provided.

Section 1525(d) specifically prohibits any physician incentive plan that directly or indirectly provides a specific payment as an inducement to reduce or limit medically necessary or appropriate services and provides additional protections to ensure that providers are not subject to unreasonable financial risk.

Section 1531—The committee rejected the President's proposal to terminate essential community providers (ECPs) after 5 years and decided instead to extend ECPs indefinitely. This action recognizes the critical role these providers play, and will continue to play, in a reformed health system in assuring access to health services for low- to moderate-income and other underserved populations.

SUBTITLE G

Approval of State implementation plans

Sec. 1611—The committee intends for the board to provide for the State implementation document filed by each State to include information about the boundaries and population characteristics of health care coverage areas designated by the States in order to assure that such boundaries are drawn fairly and without respect to expectations about the utilization of health care services by populations or sub-populations with each designated area and that such boundaries do not violate section 1914 of this act. The board shall reject State implementation plans that designate boundaries in violation of section 1914. Such a rejection shall be accompanied by a description of how the boundaries should be redesignated to bring the State implementation plan into compliance with the act.

Capital standards

Sec. 1651—The committee intends, through subsection (d) of this section and section 1674, to encourage the growth of public and not-for-profit health plans that are owned or operated by consumers or by local, community-based providers. The committee believes that these plans may offer local residents a great role in the development of plan priorities, resource allocation decisions and efforts to improve the health status of the community as whole. The committee intends that the Board issue regulations under this section that would identify alternative financial instruments states could allow such plans to use to meet the minimum capital standards established under subsections (b) and (c). The Board may include in its consideration of applicable financial instruments under this section the following: the purchase of reinsurance, letters of credit,

surety or performance bonds, subordinated debt and financial guarantees. Community- and provider-based plans are also eligible under section 3134(d) for planning grants totalling \$27 million over 6 years if they are located in medically underserved areas.

Enrollment rules

Sec. 1660—The committee intends that the Board, in its promulgation of rules under this section, establish direct enrollment mechanisms. The committee intends for these mechanisms to be utilized primarily by the self-employed and families that are unconnected to the work force, although many of these individuals may choose to enroll through a cooperative. For working families, the principle point of enrollment will be through a cooperative. For working families, the principle point of enrollment will be through consumer purchasing cooperatives or through the workplace in accordance with section 1403.

The committee intends that enrollment forms used by employers and in the direct enrollment processes established by the Board be easy to read and simple to complete. The committee further intends that forms for direct enrollment to be available at convenient locations such as schools, Government agencies, post offices, banks, grocery stores, shopping centers, provider sites, outreach sites and meal sites. Enrollment should be allowed to take place by person, mail and toll free telephone. Self declaration statements should be allowed to the maximum extent feasible. Enrollment assistance should be available on request for the elderly, people with disabilities, low income families, resident of rural areas and others who need help to enroll. Enrollment should be as automatic as possible, including enrollment at birth and the time of reaching the age of eligibility as an individual.

The committee further intends that the Board issue regulations interpreting "disenrollment for cause" to include failure to resolve disputes in a timely manner or substantial failure of a plan to act in accordance with the plan requirements described in subtitle F of this act.

Medical technology assessment study

Sec. 1672—Establishes an interdisciplinary study in the Agency for Health Care Policy and Research (AHCPR) in the Department of Health and Human Services (HHS) for the assessment of the impact of medical technologies. The study will assess the impact of old, new, and emerging medical technologies on health care costs, social costs and patient outcomes. Medical technologies include drugs, biologics (including vaccines), medical devices, drug delivery systems, survival services and other procedures for preventing, diagnosing, and treating disease.

AHCPR will consult with an expert advisory committee, the Institute of Medicine, and consider public comments to develop a study design and to select the conditions to be studied. AHCPR will select diseases for study based on criteria relating to aggregate costs, importance to public health, potential for improved patient outcome management and other factors identified by the advisory committee. Following public comment on the draft report, the Secretary of HHS shall submit to Congress recommendations deemed

necessary to ensure the availability of, access to, and appropriate use of medical technologies that improve the quality of health care in the United States.

The development of new medical therapies and technologies such as prescription drugs, medical devices, and surgical techniques has led to dramatic improvements in health and quality of life. Utilization of these measures has also contributed historically to rising health care costs. The committee finds that practitioners, insurers, and patients are increasingly in need of reliable effectiveness information to facilitate the selection of the most appropriate medical interventions.

The Health Security Act originally provided for the creation of an Advisory Council on Breakthrough Drugs. Created to meet concerns over the high cost of new drugs, the Advisory Council would have focused on only one segment of the drug industry, breakthrough products, and only on their introductory prices.

The committee found that the Advisory Council might have had a disproportionate impact on biomedical research and the development of biotechnology products. The Advisory Council was replaced with a mandated study conducted by the Administrator of the Agency for Health Care Policy and Research (AHCPR) in the Department of Health and Human Services, assessing the impact of all forms of medical technologies, not just breakthrough drugs, on health care costs, social costs and patient outcomes.

The committee recognizes that health care providers also need assistance in making objective comparisons of the medical technologies that will become more widely available under health reform. The medical technology assessment study will give information to health care providers about the full range of health technologies, including drugs, medical devices, and surgical services. The report will examine the impact of medical technologies on patient outcomes, quality of life, and the economy.

In order to ensure a balanced and objective report, the Agency is required to consult with a balanced expert advisory committee while preparing its report. The advisory committee will consist of medical technology assessment experts, physicians, bioethicists, consumers and patient advocates, and others.

Advisory opinions

Sec. 1674—The committee intends that this section provide for access to prompt advisory opinions (within 90 days) from appropriate Federal entities as to whether groups that have applied to qualify as community- and/or provider-based health plans, as defined in section 1651, comply with applicable Federal laws. Access to these opinions is intended to be limited to health plans or prospective health plans; access is not intended to be extended to individual providers, laboratories, or other organizations that do not provide clinical health services.

Essential community providers

Sec. 1682—The committee intends that for purposes of certification as an essential community provider, the category of public and private, nonprofit mental health and substance abuse provid-

ers includes any alcohol detoxification center receiving funds under title V or XIX of the Public Health Service Act."

Wellness programs

Sec. 1687—The committee intends for the Secretary to develop wellness program qualification guidelines under subsection (d) of this section that assign point values to various wellness activities including, but not limited to, the program elements described in (d)(1). Such guidelines shall allow employers, by choosing combinations of activities, to qualify for each wellness program level designated by the Secretary in a manner that allows the employer to tailor such a program to the needs of the employer's work force.

Participation in OPM Insurance Program

Sec. 1707—The committee intends that citizens and residents of the United States who work for American companies (other than on a short-term, basis) outside the United States are assured the opportunity to purchase health insurance through the Office of Personnel Management. In accordance with the regulations and standards issued by the Board, OPM will create separate risk pools for Federal and nonfederal workers abroad. This will ensure Federal employees will not experience any changes in their premiums as a result of this program.

There are no premium discounts or subsidies available to either individuals or employers in this program. Additionally, individuals must pay a surcharge to cover the increased administrative expenses.

It is the sense of the committee that OPM should investigate expanding the definition of "American employer" to include subsidiaries of American corporations.

The committee intends to work closely with the Committee on Government Operations to make any necessary adjustments or modifications to existing governmental programs in order to implement this section.

Antidiscrimination provisions

The touchstone of the universal health care coverage guaranteed by the act is that every American must be afforded the opportunity to obtain health care coverage from health plans operating in his or her community. It is sad but true that blatant and subtle forms of discrimination often operate to keep individuals from obtaining health care services. Some of this discrimination takes the form of blatant refusals to enroll or to treat individuals on the basis of their individual characteristics.

Other discrimination is more subtle, but no less effective. It is no secret that some individuals have greater need for health care services—and thus are more expensive to cover—than others. The committee has received ample evidence that those who offer health care coverage and services may engage in a broad variety of discriminatory practices to avoid actually providing services to these high cost individuals.

For example, health plans have "redlined" minority and low-income communities to avoid providing coverage to those who live there. Physicians and other providers are barred from joining plans

because of their own characteristics, or because of the characteristics of those whom they treat. Plans market their services in minority communities, but refrain from locating facilities there because of the high cost of providing services to patients who do enroll. Similarly, there are reports that health insurers have denied coverage to persons who do not speak English. These are but a few of the subtle forms of discrimination that can undermine the universal health care coverage guarantee by the act.

Too many individuals have limited or no access to certain health care services or programs because of their gender. Pregnant women often cannot receive needed drug and/or alcohol treatment because many treatment programs exclude pregnant women as a matter of policy. Thus, many pregnant women are denied access to much needed health care services simply because of their gender.

Other individuals receive low quality or inadequate health care services because of their income, race, national origin, or gender. For example, some hospitals have been found to house maternity patients on different floors based on whether the patients pay through private health insurance or are covered by Medicaid. Some also have been accused of segregating patients based on race and national origin. Such patient segregation can mean different levels of care to patients solely based on their personal characteristics. Similarly, a number of health care facilities remain inaccessible to persons with disabilities.

A comprehensive ban on discrimination in connection with the provision of health care services is thus critically important to assure that all Americans actually have available to them the health care coverage provided by the act. For that reason, section 1914 prohibits the National Health Board and any State, health plan, consumer purchasing cooperative, large group sponsor, employer, or other entity subject to the act from discriminating in connection with the provision of health services on the basis of race, national origin, sex, religion, language, income, age, sexual orientation, disability, health status, or anticipated need for health services. Consistent with the bill's purpose of assuring that all Americans enjoy health care coverage, the bill specifies that it should not be construed to prevent a person from engaging in activities to encourage the enrollment of community-rated individuals residing in underserved areas.

Similarly, the act does not bar taking into account the ability of particular health care providers to speak the languages spoken by the patients they will serve. At the same time, however, the act does forbid covered entities to refuse to enroll people in health care plans on the basis of language, or to refuse to provide services in an area where many people do not speak English.

The factors as to which discrimination is prohibited reflect those enumerated in the Health Security Act, and the addition of sexual orientation. Certain of the categories enumerated in the bill—health status, anticipated need for health services, and income—have not been bases for traditional civil rights protections. These categories are included in the Act to assure that entities subject to the act do not attempt to undermine the statutory objective of assuring universal coverage by seeking to avoid providing health care

services to populations that may be more expensive than average to treat.

Discrimination on the basis of sexual orientation is far too common. A recent survey of the American Association of Physicians for Human Rights found that 67 percent of the respondents reported knowing of gay, lesbian or bisexual patients who had been denied care or received substandard care because of their sexual orientation. According to a study by the Office of Technology Assessment (OTA), 30 percent of private insurers and 25 percent of health maintenance organizations considered homosexuality in their underwriting practices. This is true despite the fact that in 1987, the National Association of Insurance Commissioners (NAIC) issued guidelines recommending against using sexual orientation in underwriting. The OTA reports that some insurers hired inspection agencies to confirm suspicions of homosexuality by interviewing a proposed insured's neighbors.

It is particularly important to ban discrimination on the basis of sexual orientation because health care plans may seek to avoid including gay men, because of fear of the increased incidence of H.I.V. No person should be denied health care services on the basis of his or her sexual orientation. Such conduct is unjust and fundamentally inconsistent with the goal of universal coverage, and with community rating. While the act generally prohibits discrimination on the basis of sexual orientation in connection with the provision of health care services, a provision was included to specify that the act does not require or prohibit the provision of benefits to an employee for the benefit of his or her same-sex partner.

Existing civil rights laws have significant gaps that would allow discrimination to occur that would frustrate the act's fundamental purpose. For example, title VI of the Civil Rights Act of 1964 prohibits discrimination by recipients of Federal financial assistance, and only on the basis of race and national origin. The Age Discrimination Act similarly prohibits discrimination on the basis of age in federally funded programs. Only health providers that receive Federal financial assistance are covered by these statutes. Health insurers and health plans that do not receive Federal financial assistance are not subject to these statutes. Moreover, no civil rights law prohibits discrimination in health care on the basis of gender, religion, or sexual orientation, income, health status, or anticipated need for health services.

The committee intends the antidiscrimination provisions in the bill to supplement existing laws. Nothing in the act should be construed to limit the scope of, or the availability of relief under, any other Federal or State law prohibiting discrimination or providing relief therefor.

The antidiscrimination provision applies to the National Health Board and any State, health plan, consumer purchasing cooperative, large group sponsor, employer, or other entity subject to this act. The committee intends this provision to be construed broadly to cover entities regulating, marketing, promoting, insuring, and providing health care services, and all entities subject to the act, so that individuals seeking to obtain health care services are assured that those services will not be limited in any way on the basis of race, national origin, sex, religion, language, income, age,

sexual orientation, disability, health status, or anticipated need for health services.

Section 1914(b) gives some examples of the kind of activities in which discrimination is prohibited. These include: establishing the boundaries for health care coverage areas, premium areas and service areas; enrolling or terminating the enrollment of persons in a health care plan or marketing a health care plan; and determining the scope of services provided by a health care plan, and providing such services; or determining the site or location of health care facilities. This list is intended to be illustrative and not comprehensive. The bill bans all discrimination in connection with the provision of health care services.

Section 5238 provides that the standards used to determine whether a violation has occurred in a complaint alleging discrimination on the basis of age or disability under section 1914 shall be the standards applied under the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.) and the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.).

Applying the standards of the ADA in the health care context requires that, in order to ensure that a health plan does not deny or limit access to or the availability of health care services on the basis of disability, each provider must remove architectural barriers that are structural in nature in existing facilities where such removal is readily achievable and all services provided by the plan are readily accessible to and usable by individuals with disabilities when viewed in its entirety. Section 501(c) of the ADA addresses insurance by requiring, among other things, that the terms of a *bona fide* benefits plan be based on sound actuarial data and not be used as a subterfuge for discrimination; this provision is inconsistent with the requirements of this act requiring universal coverage, and thus the committee intends that the requirements of this legislation control.

Section 6103(b)(1) of the Age Discrimination Act provides that "it shall not be a violation * * * for any person to take action otherwise prohibited * * * if (A) such action reasonably takes into account age as a factor necessary to the normal operation * * * of the program; or (B) the differentiation made by such action is based upon reasonable factors other than age."

Remedies: Discrimination

Where discrimination has occurred in violation of the act, section 5238 makes available 3 kinds of remedies: private civil actions, administrative action by the Secretary of Health and Human Services, and suit by the Attorney General. This is the same model followed under other civil rights statutes, including the Fair Housing Act.

Persons aggrieved by a violation of section 1914 may commence a civil action against the parties who committed the violation in an appropriate State court or in Federal district court. In such an action, if the court finds that discrimination occurred in violation of section 1914, the court may award such equitable and injunctive relief as it deems appropriate, and any sums lost as a result of the violation.

In addition, if the court finds that the party committing the violation engaged in intentional discrimination, the aggrieved person may recover compensatory damages. If the court finds that the party or parties committing the violation did so with malice or reckless indifference to the Federally protected rights of the aggrieved person, the aggrieved person may recover punitive damages under this section against a defendant other than a Government agency or political subdivision. These rules are in accord with those applied under other civil rights statutes, including the Fair Housing Act; 42 U.S.C. §§ 1981 and 1983; title IX of the Higher Education Act; and under the Civil Rights Act of 1991, for violations of title VII of the Civil Rights Act of 1964, and title II of the Americans with Disabilities Act of 1990.

In civil actions brought under section 5238, the court, in its discretion, may allow the prevailing party, other than the United States, a reasonable attorney's fee (including expert fees and other litigation expenses) as part of the costs, and the United States shall be liable for costs the same as a private person. This provision is substantially identical to the attorney's fees provision in title VII of the Civil Rights Act of 1964, and other civil rights laws. A prevailing defendant can recover attorney's fees upon a showing that the action was frivolous, unreasonable, or without foundation, even though not brought in subjective bad faith. That is in accord with the rule announced by the Supreme Court in *Christiansburg Garment Co. v. EEOC*, 434 U.S. 412, 421 (1978) under Title VII of the Civil Rights Act of 1964.

Whenever the Secretary of Health and Human Services finds that a party has failed to comply with section 1914 or with an applicable regulation issued under such section, the Secretary shall notify the party. If within a reasonable period of time the party fails or refuses to comply, the Secretary may (1) refer the matter to the Attorney General with a recommendation that an appropriate civil action be instituted; (2) terminate or limit the participation of such party in the programs authorized by this act; (3) withhold Federal financial assistance to the party; or (4) take such other action as may be provided by law. The committee intends that the Secretary follow the same procedures set forth in title VI of the Civil Rights Act of 1964 for terminating or limiting participation of a party in programs authorized by the act.

When the Secretary refers a matter to the Attorney General, the Attorney General may bring a civil action in a district court of the United States for such relief as may be appropriate, including injunctive relief. In a civil action under this section, the court (1) may grant any equitable relief that the court considers to be appropriate; (2) may award such other relief as the court considers to be appropriate, including in cases of intentional discrimination compensatory and punitive damages; and (3) may, to vindicate the public interest when requested by the Attorney General, assess a civil money penalty against the party in an amount not exceeding \$50 for a first violation; and not exceeding \$100,000 for any subsequent violation.

TITLE II

PART 1—STATE PROGRAM FOR HOME AND COMMUNITY-BASED
SERVICES FOR INDIVIDUALS WITH DISABILITIES*Entitlement to services*

Sec. 2101(b)—Under the State program to provide home and community-based long-term care services to individuals with disabilities, any State with an approved plan is entitled to receive funding for services provided in accordance with its plan. There is, however, no entitlement to receipt of services by any individual who meets the eligibility criteria. Because the program is designed as a capped entitlement to the States, and is phased-in gradually, there may be instances in which States must limit the availability of services to eligible individuals. States are, however, legally required to fulfill any obligation or responsibility undertaken upon receipt of these funds.

Initial screening

Sec. 2102(a)(1)(B)—The agencies that conduct eligibility determinations and develop care plans for program participants may not have a direct interest in the provision of services. With certain exceptions, the committee has required a separation of these functions in order to avoid conflicts of interest. It is permissible for one agency to both conduct assessments and perform care management functions, however, in general, assessment/care management agencies would be expected to contract with separate agencies that would directly provide the services authorized under the care plan.

An important issue in State implementation will be the ability of States to develop adequate referral relationships so that provider agencies (1) begin services in a timely manner and (2) assure adequate continuity of care. Clients should not be required to have additional contact with the agency that provides services. The function of the care manager should be to arrange for the provision of services, if desired by the client.

Screening agency exceptions

Sec. 2102(a)(1)(C)—There is a statutory exception to the conflict of interest provisions for providers of residential care. This exception is intended to pertain to community supported living arrangements for persons with mental retardation/developmental disability. In such arrangements there characteristically has been a closer and more continuous relationship between the assessment, care management, and service delivery functions.

Continuation of services

Sec. 2102(a)(1)(E)—This Section requires States to continue to provide adequate services to individuals who, as of the date of enactment, receive home and community-based services under the Medicaid State plan. It is the Committee's intention that individuals who currently receive home and community-based services through a Medicaid waiver would also be entitled to continue to receive an appropriate level of services. This section does not, however, entitle any category of individuals to services.

Taking into account informal care

Sec. 2102(a)(2)(C)—While a State plan may take into account the availability of informal care in determining the amount and array of services made available to a covered individual, it is not intended that informal caregivers be compelled to unwillingly provide services. It is the belief of the committee that many informal caregivers want and intend to provide many services to family and friends with disabilities. However, the committee does not believe that it is in the best interest of individuals with disabilities to compel informal caregivers to provide more services than they are willing and able to provide. Therefore, this section requires that any care plan that includes informal care be required to verify, on a case-by-case basis, the actual availability and appropriateness of the informal care, and not simply assume that it will be provided.

Allocation

Sec. 2102(a)(2)(D)—In demonstrating the manner in which services will be allocated, the State plan must, within the limits of available funding, attempt to provide services that are sufficient in amount, duration, and scope to provide a substantial assistance in living independently. The intent of this provision is for States to attempt, within the limits of available funding, to provide a more adequate package of benefits to a smaller number of eligible individuals, rather than a sparse package of services to a larger number of individuals. It is not intended to constitute an entitlement for any individual to any particular services or a guarantee that the services provided through this program alone will assure the ability to live independently.

Coordination

Sec. 2102(a)(9)(C)—With regard to the requirement that the State integrate services under its plan with other relevant Federal and State programs, the committee intends that councils and advisory bodies created under those Federal and State programs be involved in the development of the plan, to the extent practical. The involvement of these councils and advisory bodies is critical to the development of a consumer-driven, coordinated system of home and community-based services. Of particular importance will be the involvement of these councils in how the State designs and implements systems of service delivery for children under both subpart A and subpart B of this title.

Terminology

Sec. 2102(a)(13)—The State plan submission must adhere to uniform definitions of terms, as specified by the Secretary. The intent of this requirement is not to require that all States offer a uniform package of benefits, but rather, that all States call services offered by the same name. Establishment of uniform terminology is critical to the ability to collect comparable data and, thereby, assess program effectiveness across States and nationally.

Individuals with disabilities defined

Sec. 2103—In determining eligibility for services under the program, the definition of disability includes four categories, which

take into account the distinct types of functional impairment associated with different disabilities. These definitions will help to assure that persons with physical and mental conditions who are severely impaired will be covered. However, the four categories should not be considered mutually exclusive. A person with severe cognitive impairments may be deemed eligible under either subparagraph (1) Individuals Requiring Help with Activities of Daily Living, subparagraph (2) Individuals with Severe Cognitive or Mental Impairment, or subparagraph (3) Individuals with Severe or Profound Mental Retardation.

A child may qualify as an "individual with a disability" under any of subparagraphs (a)(1) through (a)(3). In addition, for children under 6 years of age, there is an additional set of eligibility criteria. These young children will be found eligible if they have a severe disability or chronic medical condition that limits functioning in a manner that is comparable in severity to the standards established under paragraphs (1), (2), or (3).

Because young children typically require some assistance in daily living activities, it will often be inappropriate to evaluate them based solely on their need for assistance with activities of daily living. Instead, the committee intends that the Secretary adopt a functional analysis that examines whether the child is functioning independently, appropriately and effectively in an age-appropriate manner. If the child is experiencing developmental delays that are comparable in severity to the level of disability described in one of the other categories of individuals with disabilities, the child should meet the definition set out in this subsection. In the case of infants, the Secretary may wish to adopt a standard that evaluates a child's expected functional deficits based on factors such as birth weight, responsiveness to stimuli, or need for assistive technology.

Recognizing that these eligibility criteria may not adequately measure severe impairment in all cases, States may use not more than two percent of their annual allotment to serve individuals with disabilities that are comparable in severity to the criteria described in section 2103(a), but who fail to meet the criteria of any single category. For example, an individual with a severe sensory disability and significant cognitive deficits might be determined to have a comparable disability under section 2103(b)(2).

The intent of this provision is to allow care managers some appropriate discretion in determining program eligibility. The purpose of this flexibility is to allow severely disabled individuals who may have a combination of disabilities, yet fail to meet the criteria of a single category, to receive services. It is not meant to broaden the eligibility criteria to persons with lesser levels of disability. It is the intent of the committee that States report to the Secretary on now they make decisions about allocating services under this provision. Such reports will aid in the refinement of eligibility criteria to be used in the future.

The duration requirement—that a disability must be expected to last for no less than 90 days in order for an individual to be eligible for services—is intended to assure that services are targeted to persons with long-standing and persistent needs. There are many conditions that could lead to a level of functional impairment that is

not expected to last more than a relatively short period of time, e.g., an individual recovering from serious surgery. Services to assist such individuals are appropriately provided as a post-acute or extended care benefit.

The duration requirement should not be interpreted to exclude individuals with chronic physical or mental conditions that are characterized by exacerbations and remissions, who may require services intermittently for periods less than 90 days. The committee expects that, in developing regulations to implement these provisions, the Secretary will take into consideration the special circumstances of persons with chronic conditions that may be only intermittently disabling.

Requirement for care management

Sec. 2104(b)—While States must make available a full range of care management services, this requirement does not prevent a program participant from electing to direct his or her own services, including hiring or firing providers.

Home and community-based services

Sec. 2104(b)(2)—The requirement that the Secretary develop a uniform comprehensive assessment tool should not be interpreted to mean that one assessment tool will be appropriate for all categories of eligible individuals. It is intended that the Secretary develop, and the States use, a uniform comprehensive assessment tool for *each* eligible group of individuals.

Mandatory coverage of personal assistance services

Sec. 2104(c)—States are required to provide personal assistance services to help all categories of eligible individuals, however, no individual is entitled to receive such services. The receipt of services is contingent upon the results of the comprehensive assessment, the individualized care plan, and the availability of funds.

Personal assistance services

Sec. 2104(g)—The personal assistance services required to be offered to all categories of individuals with disabilities are not intended as an entitlement for any individual to receive services, but rather, must be offered within the limits of available funding.

The definition of personal assistance services clarifies that for people with primarily mental or cognitive impairments, such services should include hands-on and standby assistance, supervision, or cuing with such instrumental activities of daily living as may be necessary for the individual. Such instrumental activities of daily living may include, for example, housework and laundry, meal planning and preparation, grocery shopping and transportation, taking medications, and use of telephones. This definition will increase the likelihood that services needed by individuals with primarily mental or cognitive impairments will be appropriate to meet their needs.

Recommendation of the Secretary

Sec. 2105(c)—Because certain individuals may be eligible to receive a substantial amount of services under this program, it is

conceivable that the required cost-sharing would pose an obstacle to an individual's ability to afford all needed services. For this reason, the Secretary has been directed to establish a method for reducing the cost-sharing burden on individuals with extraordinary out-of-pocket costs whose ability to take advantage of services could be jeopardized.

The Secretary could recommend, for example, that States establish a limit on out-of-pocket costs as a percentage of gross income, or as an absolute dollar amount similar to the out-of-pocket cap under title I.

Determination of income for purposes of cost sharing

Sec. 2105(d)—In determining income, States must follow uniform Federal definitions of income, including any allowable deductions from income. The Secretary should consider the viability of permitting or requiring the deduction of all disability-related expenses in establishing an appropriate methodology pertaining to this section and section 2105(c).

The Internal Revenue Code currently allows the deduction of some disability-related medical expenses, and the committee believes that it is appropriate to allow for similar deductions from income for purposes of cost sharing in the new home and community-based long-term care program.

Federal standards

Sec. 2106(b)—It is expected that the Secretary would specify the information that must be maintained by States on program applicants in order to monitor the eligibility determination process. It is the Committee's intent that the Federal Government review a sample of applicants to evaluate the results of the eligibility determination process. States would also be required to propose, establish, and implement a system to periodically evaluate the appropriateness and monitor outcomes of the comprehensive assessment, care planning, and service authorization functions. The Department of Health and Human Services (HHS) would review the evaluation results. It is critical that States develop monitoring processes that assure objective data on agencies under review and providers.

It is expected that State plans would specify a quality assurance process that reviews hearing grievances and appeals by individuals adversely affected by eligibility, assessment, or service authorization decisions. While States must develop and make public a registry of agencies/home care workers against whom complaints have been sustained, consumers are not prohibited from selecting a provider or home care worker whose name appears on such registry.

Client advocacy activities

Sec. 2106(c)—States that participate in the home and community-based long-term care program are entitled to a separate allocation that may be expended only for client advocacy activities. The committee intends that States use funds made available under this allocation to pay entities that employ individuals with demonstrated relevant experience in providing client advocacy services to the eligible populations.

Functions

Sec. 2106(d)—This bill requires the establishment of a client advocacy office to investigate and resolve complaints. Functions that should be undertaken by this office include taking measures to assure the nondisclosure of the identity of complainants or clients without their permission; establishing procedures for appropriate access to client records, with the permission of the client or guardian; collecting and analyzing data relating to complaints and conditions and publishing an annual report with recommendations; assuring that the client advocacy office is free from conflicts of interest; and assuring that representatives of the office are protected from liability for good faith performance and that willful interference with representatives of the office in the performance of the official duties of the representatives shall be unlawful.

Subsection 2106(d)(1)(E) requires the client advocacy office to represent the interests of clients before governmental agencies and seek remedies to protect the health, safety, welfare, and rights of clients with regard to the provisions of this Title and related concerns under this act. It is the intent of the committee that representation provided under this subsection be made available to title II beneficiaries with regard to long-term care services for which they are eligible under this title. However, a title II beneficiary who also requires representation with regard to related services offered by another title of the act should also be eligible to receive such representation through the client advocacy office. It is not the committee's intent that such an individual be required to seek representation from multiple offices.

Advisory groups

Sec. 2107—The Secretary is required to establish a Federal advisory group, and participating States are required to establish advisory groups at the State level on all aspects of the home and community-based long-term care program. A majority of the members of advisory groups at both levels are required to be individuals with disabilities or, where appropriate, their representatives. To facilitate the participation of individuals with disabilities in advisory group activities, the committee believes that staff support, travel, and related expenses for members of the Federal and State advisory bodies, respectively, should be made available, including reimbursement of disability-related costs (such as the cost of personal assistance services, respite care, et cetera) incurred in connection with participating in advisory group activities.

Payments to States

Sec. 2108(a)(2)—States should be prepared to document the appropriateness of activities classified as quality assurance. For example, while some functions of a care manager may be appropriately classified as quality assurance activities, most will not.

Children with disabilities

Sections 2111–2117—The committee recognizes that appropriate medical and social services are necessary for the care of children with disabilities, and this is primarily accomplished through adequate health insurance and medical services. The committee be-

believes that timely and appropriate interventions are preventive measures to avert more significant disability-related conditions and costs.

The committee is concerned that health insurance and medical services for children with disabilities are currently inadequate or unavailable. Severe limitations on reimbursable services, health insurance practices such as exclusion for preexisting conditions, and restriction eligibility standards for Federal-State public assistance programs have left a larger number of families with children with disabilities impoverished, uninsured, to having or institutionalize the child for medical care.

The committee is very concerned about the ongoing difficulties that families face with acquiring necessary medical services for disabled children. Numerous committee hearings have been held on the impact of health care reform on children and adults with disabilities. Families frequently face two very difficult options: (1) become impoverished in order to keep the child at home; or (2) place the child in an institution for care. Family members often find themselves in difficult job-lock situations in order to maintain their current level of medical coverage.

In response to these concerns, the committee has authorized a new State program for extended services for children with special health care needs. The committee intends that the program will assist families in retaining, or acquiring, necessary medical services for children with disabilities and chronic conditions when coverage for these is not available in the basic benefits package, through Medicaid or part A of title II. The extended services program is designed to augment medical services covered under the family's basic health insurance plan. Constraints on length of services or type of services in the basic benefits package may leave families without reimbursement for certain services, resulting in costly medical bills. This program allows families to acquire necessary services through cost-sharing provisions.

The committee believes that these services should be designed to meet the needs of the individual child through family centered programs and culturally competent providers. This means that family members are to be involved in the development and implementation of their child's plan of care in partnership with the child's health provider. Culturally competent providers are those individuals familiar with and respectful of the linguistic and cultural characteristics of the child and family to be served.

The committee requires an individualized needs assessment and plan of care that is updated semiannually in order to assure that appropriate services are matched with the medical needs of the child. The committee intends that the plan of care shall list specific services, identified delivery systems, and plan for coordination with other health care services provided under the act. The committee views coordination as a critical component to ensure maximum benefits through the appropriate section of this act, and to provide a seamless system of care for children with special needs.

The committee requires certain extended services to be provided under every State plan. Developmentally appropriate personal assistance services—such as private duty nurses, nursing assistants, or other trained professionals recognized by the State—assist chil-

dren and their caregivers meet basic daily care requirements. Care management is vitally important in arranging and negotiating the complex care needs and identifying appropriate resources. A critical feature of effective care management is family involvement in the development, implementation, and periodic modification of care plans. Respite services may be necessary in order to keep the child at home and enable family members to adequately deal with the needs of the entire family. Transportation services are included to ensure that children are able to attend medical visits as well as participate fully in social activities. Home modification is often a key component to enabling the child to function fully in the home environment. The committee permits inclusion of any other care or assistive services approved by the Secretary, and identified by the State, to maximize a child's ability to function independently and in an age-appropriate manner.

The committee requires the State to specify the selection process for the types of providers and institutions to provide the required covered benefits available through the program, and how the provision of services will meet the needs of all eligible children. The committee directs each State to designate a lead agency to administer this program and coordinate the long term care services provided with health plans, service providers and other State agencies serving children—including the State agencies administering Medicaid, titles V and XX of the Social Security Act, programs under the Individuals with Disabilities Education Act, the Developmental Disabilities Assistance and Bill of Rights Act, and other Federal and State programs that involve assistance to children with special health care needs.

The committee allows the State to use various forms of payments for services such as vouchers, cash payments directly to the child's designated representative, capitation payments to health plans, and payment to providers. Cash payment methods are important for the acquisition of limited services among rural residents and the direct control of personal services by the disabled child or the child's designee.

To simplify the application process, the committee directs that an applying State submit an addendum to the State application for subpart A with descriptive information provided on population characteristics, utilization of funds and types of services, and methods of identifying persons qualified to develop pediatric care plans.

The committee intends that all children with disabilities receive comparable services. States are required in subpart B to offer a range of specified services in their State plan that will facilitate home and community-based care for children with special health care needs. It is the committee's view that all children eligible for services under title II should receive services consistent with their needs. The committee directs the State to provide children covered under subpart A of title II access to the same range of services children receive under subpart B, or identify the limitations that prevent the State from doing so.

The committee anticipates this program will phase-in to eventually include all states, as funds become available. Initially a competitive grant program, the committee expects to convert funding allocations to a formula basis when fully implemented.

The committee intends that the program be affordable to all families and children that need it. Provisions for cost-sharing are based on annual family income. It is the committee's intent that the Secretary allow individuals and family members to deduct all disability-related expenses not otherwise covered in the act from their gross income for purposes of determining their applicable income for cost sharing purposes. The committee has also included provisions directing the Secretary to explore ways to further reduce financial barriers to care that arise, such as the establishment of a pro-rated payment system not to exceed 10% of the child's or family's monthly income.

The committee has requested an interim Federal program evaluation, to be included with the evaluation report of subpart A programs, of the extended services benefits for children with special health care needs. The committee expects this evaluation to include at minimum the following: the state's effectiveness in meeting the needs for home and community-based services for eligible children; access to services; quality of long term care services for children; program effectiveness in containing the costs of long term care, and in limiting the share of such costs borne by individuals with low incomes; and effectiveness of achieving coordination and integration of long term care services with acute and social services, and in ensuring provision of services in the least restrictive setting possible.

PART 2—LONG-TERM CARE INSURANCE IMPROVEMENT AND ACCOUNTABILITY

Relation to State law

Sec. 2701(a)(3)—To promote uniformity and consistency, the bill allows States to adopt standards that are in addition to the Federal standards, but only if such State standards are not inconsistent with or in conflict with the Federal standards. The committee seeks to balance the desire of States to regulate in the area of long-term care insurance with one of the objectives of the bill which is to promote uniformity and consistency among the States in the regulation of long-term care insurance. In this provision, the committee intends to prohibit States from adopting standards that would prevent insurers from complying with the provisions of this bill or that would provide for a lower level of protection to consumers.

The legislation permits States to adopt standards that provide greater protection to policyholders. The committee intends that States be allowed to adopt standards, for example, for higher loss ratios for long-term care insurance policies or to require that all policies include a benefit to protect against the effects of inflation.

The committee intends that this bill shall in no way restrict a State's ability to enforce State law or to provide a private right of action with respect to matters affecting long-term care insurance policies.

Annual reports

Sec. 2711(b)(6)—States with approved regulatory programs will be required to file an annual report with the Secretary for the purpose of demonstrating compliance with the requirements of the act.

The annual report required under subsection (b) should be sufficiently detailed to provide the Secretary with an accurate overview of the state's regulatory program and to inform the Secretary of any material changes in law or practice related to long-term care insurance. The report is not intended to be administratively burdensome or to require reporting about specific policies, complaints, or other regulatory matters unless specifically required by the act, such as issues pertaining to 30-day violations.

Regulation of sales practices

Sec. 2712(b)—The committee believes that private long-term care insurance should not be sold to persons whose levels of income and assets make them unsuitable purchasers. The NAIC has circulated draft "suitability" standards which propose establishing \$30,000 in income and assets as the minimum financial standard for purchase. The Committee, however, recognizes that individuals make purchase decisions depending on their personal and financial circumstances. Therefore, the committee intends that financial minimum standards be advisory in nature and recognize an individual's personal circumstances. The committee does not intend to prohibit States from setting minimum financial standards for the sale of private long-term care insurance, as were enacted recently by the State of New York.

Prohibition of sale or issuance of duplicate service benefit policies

Sec. 2712(d)—The legislation intends to prohibit the sale or issuance of insurance that provides protection already held by a person and coordinates benefits, thus rendering the insurance of no value to the individual. While the provision specifically permits the sale of replacement policies, the sale or issuance of additional long-term care insurance policies is not, per se, prohibited where another policy is sold or issued to a person to supplement benefits under an existing policy. For example, a consumer may wish to purchase another policy to combine coverage where benefits under the additional policy are fully payable without regard to other long-term care benefit coverage.

Standards on compensation for sale of policies

Sec. 2713(e)—The committee intends that the total compensation for the sale of the first year of a long-term care policy not exceed either 200 percent of the commission or other compensation paid for selling or servicing the policy in the second year or 50 percent of the premium paid on the first year policy.

Upgrade for current policies

Sec. 2714(c)—The committee believes that all policyholders should be treated fairly. Thus, the committee expects that the NAIC will develop guidelines on the use of medical underwriting at the time of a policy benefit upgrade so that existing insureds who apply for new policies or coverage shall not be required to meet underwriting criteria more stringent than those that are applied to new prospective insureds who are subject to underwriting.

Rate stabilization

Sec. 2714(c)(3)—The NAIC recently approved a plan designed to stabilize long-term care insurance rates. This plan should serve as a model in the NAIC's development of standards in this area.

Benefit standards

Sec. 2715(a)—Given the variation in licensing requirements and type of provider services available in home health care settings, the committee intends that the NAIC should develop minimum standards for defining long-term care services and providers. Minimum standards should assure that all significant terms (including services types, provider and facility types and ADL's) are clearly defined at the point of sale and in the policy or certificate. The committee expects that the minimum standard should be described by the NAIC in a manner to prohibit the use of restrictive terms. For example, the NAIC should consider an approach that provides that if the policy defines the kind of facility, service, or provider, then such terms shall not be defined more restrictively than the definitions provided by the NAIC.

Per diem policies

Sec. 2715(c)(4)—Many long-term care policies are service-based, i.e. they require the receipt of professional long-term care services in recognized facilities or in an individual's home. However, a growing number of plan designs include the *per diem* or disability model. These policies pay a fixed daily (or other specified period) amount based upon cognitive impairment or a loss of functional capacity or disability. Once the disability is established they pay a fixed amount regardless of the receipt of professional services, even where care is rendered by an informal care giver. This paragraph is not intended to prohibit different payment amounts based on providing services in different settings.

The committee intends that this legislation recognize these product variations. Thus, minimum home health care services or nursing home services should only be required of "service-benefit" policies because "per diem" policies pay regardless of the kind of service and the payment can be used for any kind of provider.

Nonforfeiture

Sec. 2716—The committee understands that the NAIC is currently working on the form of a mandatory nonforfeiture benefit. It is the Committee's view that long-term care insurance should not be used as a savings instrument. Consequently, cash payouts are generally not an appropriate form for a nonforfeiture benefit.

Because the nonforfeiture benefit increases the policy's value, it also causes a rise in the premium. the committee expects a minimum benefit that strikes a balance between the size of the benefit and its costs, so that long-term care insurance policies are as affordable as possible.

Code of conduct with respect to endorsements

Sec. 2722—The committee intends to provide guidelines to protect consumers from instances where some organizations or associations endorse long-term care policies that do not meet minimum

standards, or where some organizations or associations providing endorsements are created for misleading or deceptive purposes. The guidelines provide that an endorsing organization or association must know the product it is endorsing, and in so knowing the product also assist consumers in making an informed decision. The guidelines also provide that an endorsing organization or association must disclose sufficient information about the nature of the organization or association and its relationship, financial or otherwise, with the care insurer to permit a consumer to make an informed decision about the value of the endorsement. Failure to follow such guidelines should be treated as unfair sales practices.

PART 3—LIFE CARE

Benefit types

Sec. 2742(b)—The bill specifically includes coverage of room and board costs that are not covered by beneficiary copayment during the initial 6 months of covered residence. This provision is not intended to exclude coverage of room and board costs that may be incurred after the initial 6 months of residence. Rather, it is expected that the 35 percent copayment at that time will generally cover the room and board costs of residents. Because this bill prohibits balance billing, residents may not be expected to pay additional charges for room and board that may exceed the statutory copayment of 20 percent during the initial 6 months and 35 percent thereafter.

Residential care facilities

Sec. 2742(e)—The committee recognizes that many individuals who require substantial long-term care assistance prefer to remain outside of a nursing facility for as long as possible. For this reason the committee requires the Secretary to study the feasibility of extending benefits under this act to services delivered in residential care facilities.

Because the Life Care Act is a new approach to providing insurance coverage for long-term care services, it is difficult to estimate the impact on premiums for services beyond those offered in nursing homes. Failure of this legislation to extend benefits beyond those offered in nursing homes is in no way intended to imply a policy preference for the delivery of long-term care services in institutions. Rather, the Life Care Act is intended to complement a new program of home and community-based long-term care services while addressing the need for better protection for nursing home care.

Current individuals

Sec. 2743(b)—This section pertains to periods of time after the initial enrollment year. After the initial enrollment period, individuals who reside in a hospital or nursing home may enroll in the Life Care program, but they are not eligible to receive benefits until a spell of illness subsequent to the current spell of illness.

Extension beyond initial year

Sec. 2743(c)(3)—Individuals who purchase coverage during the initial year of enactment of the Life Care program and who are not 35, 45, 55, or 65 years of age are subject to a 3-year waiting period for receipt of benefits. Persons who are confined to a hospital or nursing home for a period that extends beyond the initial year are eligible to enroll during the 60-day period beginning after the individual's spell of illness. It is expected, however, that such individuals would also be subject to the 3-year waiting period for benefits that applies to other initial-year enrollees.

Activation of benefits

Sec. 2743(c)(5)—This provision prohibits individuals from receiving benefits under the Life Care program within one month of the purchase of coverage. It is intended, however, that coverage could be obtained for a subsequent spell of illness, as addressed in section 2743(b).

Public education

Sec. 2743(d)—The public education campaign required by this section is especially critical for the population age 65 and older, for such persons will have a one-time-only opportunity for enrollment during the program's initial year. After the initial year, individuals are only eligible to enroll within 6 months of their 35th, 45th, 55th, and 65th birthdays.

Because the need for long-term care services increases dramatically with advancing age, it is critical that older individuals are informed as to their possible need for long-term care, the available options for paying for such care, the public programs and insurance options available for coverage, the benefits of the Life Care program, and how to enroll in Life Care, if desired.

Premium rates

Sec. 2744(c)—It is expected that the premium rates established by the Secretary will cover 100 percent of the reimbursement amount for nursing home stays. The reimbursement amount is specified in section 2746, and is equal to 65 percent of the reasonable and appropriate cost of care (or during the initial 6 months of coverage, 80 percent).

Room and board payment

Sec. 2746(c)—It is intended that individuals who receive benefits under this program will be responsible for a copayment that amounts to 35 percent of the cost of the average rate paid to nursing facilities receiving reimbursement under this program (and during the initial 6 months of coverage, 20 percent of such costs) regardless of the actual cost of room and board. It was the intent of the committee to illustrate that 35 percent of costs is generally equivalent to the portion of care that is comprised by room and board.

Regardless of how any particular nursing facility allocates costs, the copayment and the reimbursement amounts are intended to comprise payment in full for services received.

Priority payers

Sec. 2746(d)—Section 2749 indicates that a private insurer may not offer for sale a long-term care insurance policy that duplicates the coverage offered under the Life Care program to an individual who has purchased coverage under Life Care. However, it is possible that an individual may purchase Life Care benefits who already has purchased a private long-term care insurance policy that duplicates some portion of the Life Care benefit. In such cases, the private long-term care insurance policy is to be considered the primary payer.

However, it is possible that purchasers of Life Care will also purchase private long-term care insurance policies that are designed to wrap around the Life Care benefit. Such private long-term care insurance policies are not intended to be considered primary payers.

For example, a private long-term care insurance policy could be designed to cover the copayments for which Life Care beneficiaries are responsible. Such a policy would not be considered a "primary payer." Another possible scenario would be the sale of a private policy that covered nursing facility services for individuals with impairments in 2 or more activities of daily living (ADL) and converted to coverage of copayments for Life Care beneficiaries should their level of impairment increase to limitations in 3 or more ADL's. Again, such a policy would not be considered a "primary payer" vis-a-vis Life Care.

Asset protection

Sec. 2748—The amount of assets that may be protected by Life Care enrollees is equivalent to the amount of coverage purchased. It is intended that the amount of assets protected will be indexed for inflation.

Reports

Sec. 2751—This section specifies studies of the Life Care program that the Secretary must conduct, both before and within two years after the promulgation of regulations implementing this title. It is not the intention of the committee to delay the implementation of the Life Care program if such reports are not delivered according to schedule.

Integration of acute and long-term care services

In developing viable long-term care alternatives to institutionalization, the committee acknowledges the pioneering efforts of the On Lok program in San Francisco. The 1990 Omnibus Budget Reconciliation Act authorized establishment of up to 15 sites, throughout the country, designed to demonstrate the feasibility of replicating the On Lok model (popularly known as PACE—Program of All-inclusive Care for the Elderly). Today the model is being successfully employed in States such as Massachusetts, New York, South Carolina, Colorado, Wisconsin, California, Texas, and Oregon. This unique approach to comprehensive care of our sickest citizens has been found by Federal and State governments to be a cost-effective and desirable service alternative.

In a joint commitment toward better and more cost-effective care, the committee recommends that the Committee on Finance consider substantially increasing the number of PACE sites authorized. Such action would recognize the express and urgent interest of community organizations and State governments for additional programs well beyond the number authorized under present law. Programs that successfully complete a demonstration phase should then be afforded regular provider status under the Medicare and Medicaid programs. This formalization would not only regularize these programs, but would also assist in encouraging other third party payers to include PACE services in their benefits packages.

TITLE III

SUBTITLE A—WORK FORCE PRIORITIES UNDER FEDERAL PAYMENTS

PART 1—INSTITUTIONAL COSTS OF GRADUATE MEDICAL EDUCATION: WORK FORCE PRIORITIES

Subparts A and B

Allocation of specialty training slots

The bill establishes a National Council on Graduate Medical Education with the authority to limit the total number of physicians trained annually and the total number of residents in each specialty. The committee recognizes that it is necessary to increase the number of primary care physicians. However, it is vitally important that academic health centers and teaching hospitals continue to be provided with the opportunity to train the highest quality physicians, be they in primary care or in the needed specialties.

Since outstanding training programs are a national resource, the committee believes that allocation of residency slots must be made on nationwide basis. The specialty physician training programs of the teaching hospitals serve the nation, and meet a national need.

The committee intend that the National Council on Graduate Medical Education consider the extent to which an individual program has trained women and racial and ethnic minorities underrepresented in the field of medicine, or in the specialties, when allocating specialty positions. The committee also intends that when allocating specialty positions the Nation Council consider the extent to which the program has recruited training participants from rural or inner-city areas and the extent to which the program has successfully placed past participants in rural or inner-city areas.

The committee recognizes that there are many factors that contribute to a provider's choice of where to practice. Studies have shown that students recruited from underserved rural or inner-city areas are more likely than others to return to these areas to practice when their training is completed, and that physicians training in programs that rotate individuals to underserved rural or inner-city areas are more likely to locate their practices in these communities. In an effort to increase the number of providers practicing in these underserved communities, in order to be eligible to receive reimbursement for the costs of graduate medical education it is required that training programs in primary health care specialties

rotate training participants to such underserved rural or inner-city areas.

Advisory board on work force development

As amended in committee, section 3081 creates an Advisory Board on Health Care Work force Development within the Department of Health and Human Services to advise, consult with and make recommendations to the Secretary and to the Secretary of Labor on matters relating to health care worker supply and the impact of the Health Security Act and related changes in the health care delivery system on the need of health care workers regarding education, training, and other career development matters. It is the committee's intent that the Advisory Board should work in conjunction with the administration on Aging in the Department of Health and Human Services to develop a strategic plan to meet the work force needs for long-term care home- and community-based programs. The purpose of the strategic plan is to develop appropriate solutions to meeting the substantially increased need for trained workers to deliver home- and community-based long-term care. This plan should include recommendations concerning recruitment, training, and retention of, and career opportunities for, individuals in home- and community-based long-term care related fields. A report should be prepared and submitted to the appropriate committees of Congress no later than 18 months after the date of enactment of this act.

Training of health professionals

Section 3081(b) of the bill requires that programs that support projects to train additional numbers of primary care physicians and physician assistants include programs to provide interdisciplinary training for medical students, residents or practicing physicians and dental students, residents and dental hygienists to deliver primary care to individuals with mental, physical and developmental disabilities, including mental retardation, particularly those who are more than 18 years of age.

In addition, section 3081(j) of the bill amends title VII of the Public Health Service Act to support university affiliated programs, schools of medicine, and schools of dentistry to improve the interdisciplinary training of primary care physicians and dentists in the health care services needs of individuals with mental, physical and developmental disabilities, including mental retardation, particularly those who are more than 18 years of age. In addition, these entities are supported to develop, evaluate and disseminate curricula, support faculty training and retraining and continuing education activities aimed at providing primary health care services to individuals with mental, physical and developmental disabilities, including mental retardation, particularly those who are more than 18 years of age. The authorization for section 3081(j) is \$10 million.

The provisions described above reflect the committee's view that all primary health care providers must be educated regarding the provision of primary care services to individuals with physical and mental disabilities of all ages. Like all Americans, individuals with physical and mental disabilities need access of a range of primary health care services that are not directly related to their disability

and do not have to be provided by a professional who specializes in the treatment of their particular disability. For example, children with mental retardation or other mental impairments will experience the same broad array of health care needs as are experienced by other children—childhood diseases and injuries such as ear infections, broken bones, or the flu. Treatment for many of these health and mental health problems is appropriately provided by primary health and mental health providers, including physicians, dentists, and a range of nonphysician health and mental health professionals.

The committee intends that the education described in the bill focus on addressing the age-typical conditions of a person with a disability in the context of their disability and to identify, determine and provide accommodations for a patient with a disability. For example, fever is a common symptom of many childhood illnesses. However, primary care pediatricians need to know that for a child with seizure disorders, fever can have serious consequences. Similarly, a gynecologist needs to be trained in how to accommodate a woman with cerebral palsy who has muscle spasms, and how to communicate effectively with a woman with a cognitive disability. Also, training should include instruction in how to work with specialists to ensure timely access to specialty care when medically necessary or appropriate. In developing curricula for training, educators are encouraged to utilize the input and experiences of individuals with disabilities of all ages, and, where appropriate, their family members.

The bill includes provisions for training of dentists, among other health professionals. Oral diseases are among the most widespread of all chronic health conditions. According to a recent survey by the Academy of Dentistry for Persons with Disabilities, fewer than 10 percent of dentists get hands-on training on how to deliver services to individuals with mental retardation and other developmental disabilities. Dentists who do receive this training often feel comfortable and want to treat such individuals upon completion of their training. The bill will make it possible for more professionals to receive such training, and thereby make it more likely that individuals with disabilities will be treated. Without access to oral health care, for example, individuals are likely to develop oral health problems which can cause pain and impair functioning.

Subpart C—Costs of Graduate Medical Education

Graduate medical education

The country's need for an increase in the number of primary care physicians has been widely recognized. The Health Security Act provides funding for training programs of both primary care and specialist physicians that work together to help move the country towards a more balanced physician work force, one in which 55 percent of new physicians would be trained in primary care and 45 percent in the specialties.

The Health Security Act establishes an Annual Health Professions Work Force Account. The funding level in the Annual Health Professions Work Force Account for academic year 1996 is \$3.2 billion, for academic year 1997 is \$3.55 billion, for academic year 1998

is \$4.8 billion, for academic year 1999 is \$5.8 billion and for academic year 2000 is \$5.8 billion.

Throughout the country, different programs have had different training costs reimbursed. The bill ensures that training programs will not be forced through too rapid a change to a national reimbursement system. The bill has a gradual change to a point where half of reimbursements will be based on current reimbursement and half on a national rate.

The Health Security Act provides for flexibility in training program funding. Teaching hospitals, medical schools, group practices, community health centers, as well as combinations of these may all apply to be a training program eligible for funding.

In recognition of the time necessary to achieve major changes in the number of new doctors who are trained in primary care, the Health Security Act postpones the year for the primary care target to be met until the academic year 2000–01 without postponing funding.

The committee understands the special expertise of professional groups in determining which are the best training programs and determining where training shall continue; therefore, the bill allows each specialty to reach these goals voluntarily and without regulation.

With the understanding that primary care is provided by physicians from a range of fields and that some specialists are in short supply, the bill expands those physicians covered by the "primary care" goals to include: family medicine, general internal medicine, general pediatrics, geriatric medicine, OB/GYN, and specialties that are found to be in short supply. The committee intends that these "primary care" physicians have adequate primary care training as determined by the National Council.

Undergraduate medical education

In the past, undergraduate medical education has received much of its funding through medical services. Such cross subsidies of research and teaching are being lost with increasing price competition. In recognition of the crucial role that medical schools play in education and research, the bill establishes a medical school fund. The committee expects the medical schools will use these funds to train more medical students that go into primary care and train their students in community-based ambulatory care and primary care settings. The medical school should only fund faculty research that has been peer-reviewed and approved for funding.

Viability of academic health centers

At present, academic health centers and medical training programs receive some of their funding through Medicare and other funding through cross subsidies from private insurance. In an increasingly competitive market, academic health centers and medical training programs are losing current funding from private sector cross subsidies. To replace this funding, which is necessary to maintain the excellence of medical training, research, and specialized patient care, the bill includes expanded public funding. This funding is financed through an all payor fund.

The committee recognizes the central role that academic health centers play in teaching, research, and treatment of rare and unusually severe diseases, and the associated costs of that role. To ensure the continuing vitality of academic health centers and their contribution to the excellence of American medicine, the Health Security Act funds the Medicare portions of Indirect Medical Education (IME) at the level recommended by ProPAC.

The bill funds the private sector portion of Indirect Medical Education based on a ProPAC estimate of the adjustment factor (4.7 percent), phased in from 40 percent of current private sector spending in 1996 rising to 80 percent by 2000. It reviews appropriate levels of funding in the year 2000 based on a study of the status of academic health centers and their needs. The funding levels in the Annual Academic Health Center Account for academic year 1996 is \$6.28 billion, for academic year 1997 is \$7.25 billion, for academic year 1998 is \$8.22 billion, for academic year 1999 is \$9.4 billion and for academic year 2000 is \$10.64 billion.

Subpart E—Transitional Provisions

Transitional funding

As the number of physicians trained decreases, institutions training fewer physicians will undergo transitional costs. The bill provides funding for these institutions so that they will be able to continue to provide excellent care as they adjust. Transitional payments are provided for four years. The bill makes institutions which eliminate their training programs eligible for funds as well as institutions which decrease the size of their training programs. Institutions which voluntarily decrease training slots will be eligible as well as those which may lose slots if regulation is necessary.

SUBTITLE C—HEALTH RESEARCH INITIATIVES

Biomedical research

The committee finds that nearly 4 out of 5 peer-reviewed research projects deemed worthy of funding by the National Institutes of Health (NIH) are not funded. Less than 2 percent of our Nation's health care budget is devoted to health research, while the Defense Department spends 15 percent of its budget on research.

Public opinion surveys have shown that an overwhelming majority of Americans want more Federal resources put into health research and support having a portion of their health insurance premiums set-aside for this purpose. The National Institutes of Health is the preeminent health research institution in the world and research supported through the NIH has greatly improved the quality of life of our citizens.

Health research has brought the advances in the treatment and prevention of disease and disability that define our current high standards of medical practice and is key to maintaining quality. Advances such as the development of vaccines, the cure of many childhood cancers, drugs that effectively treat a host of diseases and disorders, a process to protect our Nation's blood supply from HIV, progress against cardiovascular diseases and colon, breast, and prostate cancer clearly demonstrate the benefits of health re-

search. Research has provided critical information about how to prevent disease including information about the dangers of smoking and the importance of diet and exercise in the prevention of many diseases.

Health research is the key to eliminating disease and disability and making our health care system less costly and more effective. Our scientists are on the verge of many exciting breakthroughs in gene therapy and treatments for cystic fibrosis and Parkinson's disease but these and many other breakthroughs are threatened by inadequate funding.

The committee's bill provides for a phased-in funding for the National Institutes of Health equal to one percent of health premiums required to be paid under this act. The committee intends for these additional funds to be in addition to, not a replacement of funds provided to the National Institutes of Health in the normal appropriations process. The committee does not intend to interfere with the funding decisions made through the normal appropriations process.

In recognition of the poor state of many health research facilities, 2 percent of the total amount provided for in this section would be dedicated for extramural construction and renovation of research buildings and facilities. One percent of the funds would be directed to the National Library of Medicine and an additional 2 percent would go to the NIH Director for intramural construction and renovation and other activities supported by the Office of the Director. The other funds made available under this section would be allocated to each of the NIH Institutes and Centers based on the percentage that each of these entities received of the total NIH appropriation for that year. Each Institute would decide the appropriate distribution of funds among various research priorities within the Institute.

Health services research

The committee recognizes that health services research is central to effective health care reform and meeting the future health needs of the nation. Our current investment in health services research is only a small fraction, less than one tenth of 1 percent, of health care expenditures. The committee has provided funding for increased health services research to assess and monitor the impact of health reform on the quality of care and health outcomes. This funding will also support the development of clinical practice guidelines that assure new knowledge is effectively translated into improved clinical practice and decision-making by providers and patients. The authority to develop, disseminate, and assess guidelines under this authority is consistent with existing AHCPR responsibilities and is not intended to preclude other Public Health Service Agencies from carrying out their guideline activities established under other statutory authorities.

The committee also recognizes that significant problems exist in the access and utilization of medically necessary or appropriate pediatric services for many children. It is the intent of the committee that the Agency for Health Care Policy and Research conduct and support research in a timely and appropriate manner within areas related to medical services for children. For example, the commit-

tee is very interested in research relating to the impact of various delivery systems (*e.g.*, managed care and long term care services) on quality of medical care for children, availability of appropriate clinical preventive services and the effects of early intervention on long term medical conditions, availability and quality of health services for children with special health care needs, relative costs of alternative methods of care delivery such as home and community-based services, development and dissemination of clinical practice guidelines for age-appropriate medical care, and the development of adequate risk adjustment and reinsurance methods to account for child-specific patterns of utilization and cost.

SUBTITLE D—CORE FUNCTIONS OF PUBLIC HEALTH PROGRAMS:
NATIONAL INITIATIVES REGARDING PREVENTIVE HEALTH

PREVENTION AND HEALTH PROMOTION SERVICES TO MAINTAIN AND
IMPROVE THE HEALTH STATUS OF THE AMERICAN PEOPLE

The bill includes several sections intended to improve access to clinical preventive services, public health services, and health education, and to advance leadership and policy development in public health. These efforts are intended to continue and coordinate efforts to maintain and improve the health status of the American people and their communities.

The committee recognizes that:

(1) Rates of preventable illness, disability and premature mortality are high and significant disparities exist in the health status of population subgroups including persons with low incomes, the elderly, children, and specific minority groups.

(2) The systems of care for preventing and treating mental health and substance abuse are not fully linked with the medical care system.

(3) The public health systems operating at the State and local levels—services, data, priorities—are not adequately integrated or coordinated with the medical care system.

(4) A broad approach to prevention is required that incorporates clinical preventive services, public health and community-based health promotion services, and social and economic policy to promote health.

(5) There is a need for more rigorous scientific review of the clinical effectiveness and cost-effectiveness of clinical preventive services and community-based approaches to disease prevention.

The committee intends that the National Health Board shall make recommendations in these areas in such a way as to ensure the greatest improvements in the public's health. The committee further intends that the Board shall consider mechanisms to integrate and coordinate the effective and efficient provision of the prevention programs and services provided by health plans with those of local and State health departments and other sectors of State and local Government that affect health, including education, labor, transportation, welfare, criminal justice, environment, agriculture, and housing.

PART 2—CORE FUNCTIONS OF PUBLIC HEALTH

The Institute of Medicine's report on the *Future of Public Health* describes the existing public health system as being in disarray at a time when the health of the public is under severe attack. Not only does society face the immediate crisis of the AIDS epidemic, violence, multidrug resistant TB, and other major health problems, but there are also the enduring problems, such as injuries and chronic illness; growing challenges such as the aging of our population, and the toxic by-products of a modern economy, transmitted through air, water, soil or food.

The issue of how to support and strengthen the public health system, while recognizing the fundamental responsibility of Government in protecting the health of the public is one of the challenges we now face. The committee recognizes that Federal funding for essential activities of public health, measured as a proportion of total health care expenditures, has actually decreased from about 1.2 percent in 1981 to about 0.9 percent in 1993, representing a relative decrease of 25 percent. The Health Security Act, therefore, provides increased funding to State and local health departments to strengthen the public health infrastructure and to make the public health system an integral part of the health care delivery system.

The committee intends that funds be used to:

- (1) improve surveillance and monitoring of health status and threats to public health;
- (2) strengthen the operation of public health laboratories;
- (3) enhance community-based disease control programs;
- (4) expand community-based activities including regulation and enforcement of sanitary codes, monitoring of water supplies and control of environmental hazards;
- (5) provide community-wide public health education;
- (6) support population-based outreach and linkages to health care providers;
- (7) provide community needs assessment;
- (8) support poison control centers; and
- (9) provide education and training of public health professionals.

Single application and uniform reporting system

State and local health departments now submit multiple grant applications for public health programs administered by the Centers for Disease Control and Prevention. The committee intends that eligible entities submit only a single application listing the programs to which they are applying. In addition, the Secretary must develop a uniform reporting system for collecting health data from State and local health departments.

The committee has required a study on the efforts of consolidating any or all of the eligible programs in section 3319, alternative methods for implementing a block grant program and alternative formulate for allocating grant monies. The committee intends that the emphasis of the study be placed on the potential impact of any consolidation on vulnerable populations.

PART 3—NATIONAL HEALTH PROMOTION AND DISEASE PREVENTION INITIATIVES

The committee recognizes the importance and viability of community developed health promotion and disease prevention programs that address local health concerns. In supporting these types of activities, it is the intention of the committee that priority be given to certain projects. These include projects that prevent violence against women, reduce the prevalence of chronic diseases, establish community health advisor programs, and support the development of rural telemedicine programs.

The committee is aware that recent surveys indicate that violence against women has reached epidemic proportions. The Public Health Service estimates that between two and four million American women are physically battered each year and that between 21 and 30 percent of all women in the United States have been beaten at least once. The consequences of such violence on the Nation's health care system are enormous—each year, more than one million of these women seek medical treatment for injuries caused by battering. The committee recognizes violence against women as a major public health problem. The committee intends that a comprehensive public health response focusing on primary and secondary prevention be a funding priority under this national health promotion and disease prevention initiative.

The committee notes that the Healthy People 2000 goals are exemplary in defining a range of measurable and achievable health promotion and disease prevention objectives. However, the committee notes that the goals for reducing violence against women requires further attention. Domestic violence too often results not only in injury but in loss of life. Some 30 percent of female homicides are a result of domestic violence. Our health care system can and should improve targeting and preventing homicide due to domestic violence.

The committee intends through several provisions in the bill to reduce the incidence of domestic violence, including both physical and emotional abuse, in part by educating health caregivers to recognize the symptoms of abuse and to provide counselling and to treat victims. Healthy People 2000 calls for 90 percent of the Nation's hospital emergency rooms to use established protocols for identifying, treating, and referring victims of domestic violence.

The committee also identified the prevention of chronic disease as a priority area. The committee recognizes that over 35 million Americans have a chronic health condition—diabetes, cancer, heart disease, emphysema, AIDS, chronic mental illness, dementia or injuries that cause disability. Chronic disorders account for a large portion of the nation's expenditure on health care. Prevention efforts, early detection and continuing management of chronic diseases such as diabetes, heart disease, asthma, cancer or AIDS can prevent serious complications, avoid hospitalization, reduce disability and reduce unnecessary deaths.

The committee recognizes that existing Community Health Advisor programs are performing a vital role in delivering cost-effective health promotion and disease prevention service to medically underserved families and communities. The committee views the ex-

pansion of such programs to communities throughout the Nation as a priority. Community Health Advisors, or Lay Health Workers, are members of a local community who, through limited training, develop the skills needed to provide health education and counseling, outreach, referral, enabling services, and other disease prevention and health promotion activities. Community Health Advisors encourage access to critical primary and preventive care, usually targeted at one or more of the national Healthy People 2000 goals, through their unique ability to relate to their clients. The committee understands the importance of using lay health workers who are familiar with the community to be served. However, the legislative language requiring that community health advisors be members of the community to be served for at least one year should in no way be interpreted to exclude programs that serve the homeless, migrant, or other highly transient populations. Community Health Advisors can play an important role in reducing overall health care costs because of their contribution in the areas of prevention and primary care, and they should be supported.

The committee recognizes that telemedicine can play a critical role in ensuring that rural residents have access to high quality health care. Telemedicine improves the delivery of health care by linking patients and their doctors in rural or remote hospitals with highly trained medical specialists and state-of-the-art medical technology. The committee recognizes that these linkages will allow more patients to receive care in their community and will ease the burden on health professionals practicing in underserved areas. These linkage are also intended to help rural areas recruit and retain health care providers by increasing the education and training opportunities available to providers in these areas. The committee also recognizes the administrative cost savings that can be achieved through telemedicine linkages. One of the obstacles to more extensive use of telemedicine is the lack of regulations regarding reimbursement under title XVIII of the Social Security Act for telemedicine services. Section 3343 requires the Secretary to issue such regulations by July 1, 1996.

SUBTITLE E—HEALTH SERVICES FOR MEDICALLY UNDERSERVED POPULATIONS

PART 1—INITIATIVES FOR ACCESS TO HEALTH CARE

The initiatives authorized under this part assure not only that every American has health insurance, but that every American has access to high quality health professionals and services. In the view of the Committee, these initiatives are among the highest priorities in this act.

The health providers eligible for funding under these initiatives are public and private, nonprofit entities with a track record of providing quality health services to medically underserved populations. The committee recognizes that there may be no providers with such a track record in some areas and encourages the development of new providers to serve previously unserved populations, particularly in rural areas. The committee intends that the term "medically underserved populations" encompass the meaning of the term as defined in section 330(b)(3) of the Public Health Service

Act, low-income populations eligible for subsidies under title I of this Act, and populations residing in health professional shortage areas under section 332 of the Public Health Service Act. The committee also intends that the grants, contracts, and loans awarded under this part be equitably distributed between rural and urban areas, including border areas.

Subpart B—Development of Community Health Groups and Health Care Sites and Services

The committee intends that the funds authorized under this subpart be used to improve and expand the existing delivery system for health services to medically underserved populations. Substantial investments in providers such as Community and Migrant Health Centers are required to encourage the development of Community Health Groups which can compete in a managed care environment. Also important is the development of new sites and services to reach previously underserved populations, especially in rural areas.

Subpart C—Capital Costs

The committee has provided funding for grants and loans to assist with the capital costs of developing community health groups and expanding and modernizing existing health delivery sites. Entities eligible for such assistance include, in addition to the eligible entities listed in section 3411(c), several categories of rural hospitals.

For fiscal years 1995 through 2000, the committee has authorized \$30 million annually for grants and such sums as necessary to support loans of \$200 million per year. Some of this funding may be used to subsidize interest payments on behalf of eligible entities where necessary to make a project feasible. In allocating the funding, the Secretary is directed to give priority to projects necessary to prevent or eliminate safety hazards including asbestos removal, to meet licensure requirements, and to replace obsolete facilities.

The President's proposal included a similar program for capital assistance for the development of community health groups but did not establish a separate authority for these capital projects. The committee has also clarified that the assistance is intended for the expansion of existing sites or the development of new sites, whether or not they are part of a community health group.

The providers that are eligible for this capital assistance have served as America's health care safety net, providing care for those with nowhere else to turn. Yet these institutions face an infrastructure crisis of major proportions. Their ability to finance desperately needed renovations and improvements has been compromised over time by the national recession and State and local fiscal crisis. If they are to succeed in an increasingly competitive health care system they will need assistance in meeting these capital needs.

Subpart D—Enabling and Supplemental Services

The committee intends that the funds authorized under this subpart cover the costs of those services such as translation and transportation essential to assuring access for low-income, rural and

special needs populations to the basic benefits package in title I. These funds are intended, in part, to offset the loss of benefits by individuals previously entitled to these services as noncash beneficiaries of State Medicaid programs.

PART 4—PAYMENTS TO HOSPITALS SERVING VULNERABLE POPULATIONS

The committee has increased the amounts allocated for payments to hospitals serving vulnerable populations from \$800 million per year to \$1.3 billion per year, beginning with fiscal year 1998. (In fiscal years 1996 and 1997, a portion of that amount is allocated based on the proportion of total Medicaid disproportionate share funding that is directed to hospitals in States which are participating States in the fiscal year in question.)

The Low Income Assistance allocation is intended to offset some of the additional costs incurred by hospitals serving primary low income populations. The Uncovered Services allocation will provide assistance to hospitals providing services that are not covered under a health plan or caring for individuals who are not covered. The President's plan proposed that 75 percent of the total funding for these hospital payments be directed to Low Income Assistance and 25 percent to Uncovered Services. The committee believes that substantially more funding will be needed for Uncovered Services, and therefore, in addition to increasing the overall funding level, has also increased the allocation for Uncovered Services to one-third of total funding, or 33.33 percent, with the other two-thirds (66.66 percent) allocated to Low Income Assistance.

The burden of uncompensated health care in border States is very costly to the health care providers located in that region. Allocation of Federal funding to cover care to individuals not eligible for benefits under title I is a necessary assurance that health care providers in the border region will not continue to bear an unfair burden.

The vulnerable populations payment is a partial replacement of disproportionate share hospital (DSH) payments currently provided by Medicaid. Under a system of universal coverage, DSH payments of the scope and magnitude currently available will be unnecessary; however, hospitals providing very high volumes of care to low income and uncovered populations will continue to need some assistance to offset these additional unreimbursed costs. While the vulnerable populations payments will be helpful in this respect, the committee nevertheless believes that a transition period will be necessary to allow these essential hospitals to adjust to the new competitive healthcare system. Although the committee does not have jurisdiction over Medicaid, in allocating funding for vulnerable populations payments it assumed that Medicaid DSH payments would be phased out, rather than immediately terminated, at least of the highest volume providers of care to these populations.

The committee is concerned about the potential impact of comprehensive health care reform on the ability of certain hospitals to meet financial commitments for major facilities replacement projects that may have been initiated prior to adoption of health reform legislation. Therefore, the committee takes note of the need

to avoid putting these institutions at risk, and urges further consideration of this issue in the course of the legislative deliberations over health care reform.

SUBTITLE F—MENTAL HEALTH: SUBSTANCE ABUSE

Sections 3510–3534—The Committee bill requires States to achieve the integration of their mental health and substance abuse services provided through the public sector with the benefits offered by health plans by January 1, 2001. Once a State has integrated its public system into the private system, health plans may place no arbitrary limits on care.

One of the goals of the committee in requiring integration is to eliminate the current two-tiered delivery system for these services. The separation of these services from mainstream health delivery has contributed to discrimination against individuals who need these services and resulted too frequently in the delay or denial of care, often with tragic results.

Also, there has been a financial incentive for private insurers to undertreat individuals with mental illness and substance abuse disorders, since they know that the public system will assume the costs of patients who need more than minimal mental health or substance abuse services. An integrated system will diminish this “dumping” phenomenon.

The committee intends that States begin immediately to plan for full integration of their public systems with the reformed private health care delivery system. To encourage planning, the bill requires States to report certain information on an annual basis, estimate their own spending on these services, and describe how current State and local spending on these services will be used to facilitate integration.

The information required in these reports is intended to help States, the Secretary, and other Federal agencies evaluate the extent to which mental health and substance abuse services are funded by health plans or public funding streams, as well as gaps and overlaps in funding and coverage. The committee intends that this information guide appropriations decisions on the level of Federal and State funding needed to support treatment and supportive services that are a fundamental part of treatment.

The committee recognizes that some States may be able to achieve integration before 2001. These States may petition the Secretary, who upon finding a State duly prepared, shall issue a certificate of readiness in accordance with published criteria.

The committee also recognizes that special circumstances in a very limited number of States may make integration medically inappropriate or infeasible. The committee bill allows the Secretary to waive the integration requirement for these States, as long as they provide the reasons why integration is not possible, as well a plan for how public and private services will be coordinated to the fullest extent possible.

The committee suspects that some health plans may continue the practice of “dumping” patients into any available public treatment system. After integration is achieved, the committee suspects that this dumping may have the consequence of increasing the number of individuals with mental illness and substance abuse disorders

who end up in the criminal justice system because they were unable to obtain appropriate treatment. To guard against this possibility, the committee bill requires States to report on the prevalence of mental illness and substance abuse among their prison populations and any changes in these rates. This committee expects this to provide a measure of how well these vulnerable populations are being served by the private treatment system.

The Committee's bill authorizes the Secretary to provide grants to States to develop and operate model comprehensive, managed, integrated mental health and substance abuse treatment programs. These grants would supplement other Federal and nonfederal mental health and substance abuse funds.

To receive grants, States must develop plans, describing how their population will have access, before 2001, to the full range of mental health and substance abuse services authorized in title I without arbitrary limits on care. States that cannot establish programs that meet the needs of all of their population can set priorities but must at least cover low-income adults with serious mental illness or substance abuse disorders and children with serious emotional disturbance or substance abuse disorders.

Nothing in the model comprehensive managed program is intended to replace or alter the entitlement to the mental illness and substance abuse benefit described in title I or the obligation of health plans to pay for medically necessary care. The program is intended to supplement the benefit.

The committee's bill gives States considerable latitude to determine how to organize and structure the program. Some States may choose to supplement the health plan premium to cover the additional costs of providing these benefits without limits. Other States may choose to operate the program through a separation, or "carve out," of the benefit. Health plans would then contribute a per capita amount to entities that contract to provide the full benefit, and the State would supplement these funds. The committee urges the Secretary to ensure that those States taking the latter approach can ensure coordination between health care services furnished through a health plan and those furnished through a managed State program.

The committee bill also includes eligibility criteria for States. It is important that States ensure that comprehensive managed programs promote integration of the public and private delivery systems but also that they ensure that individuals in these programs are in no way disadvantaged. For instance, the committee expects States to ensure that providers of specialized mental health and substance abuse treatment will be appropriately qualified.

The committee is aware that some States have already begun innovative programs in this area and urges the Secretary to give timely consideration to Medicaid waiver requests to facilitate implementation of comprehensive managed mental health and substance abuse care programs.

SUBTITLE G—SCHOOL-RELATED HEALTH SERVICES: COMPREHENSIVE SCHOOL HEALTH EDUCATION

PART 1—SCHOOL-RELATED HEALTH SERVICES

Section 3602 through 3604. The committee has included the Healthy Students-Healthy Schools grant program to coordinate Federal efforts and assist State and local efforts to provide comprehensive school health education programs to school-age children. Students need the information and skills to help them grow up healthy and take their place in an increasingly competitive global marketplace.

The committee acknowledges the need for coordinated, age-appropriate comprehensive school health education programs in public schools as a preventive public health measure. Recent studies have revealed that up to 50 percent of elementary school have tried smoking; nearly 40 percent of high school seniors surveyed say that have gotten drunk; and more than half of all young people report they have tried illicit drugs before graduating from high school. Categorical health education programs, frequently designed to address only one particular crisis, are not optimally effective in addressing the multiple risk factors that lead to unhealthy behavior choices such as substance abuse, violent behavior, and other personal habits adversely affecting health. Comprehensive, sequential health education programs that begin at a young age have been shown to be effective in reducing certain unhealthy behaviors such as tobacco use. According to the Centers for Disease Control and Prevention, comprehensive health education resulted in a 37 percent reduction in the onset of smoking among 7th grade students surveyed.

Despite evidence pointing to the cost effective benefits of a coordinated and comprehensive approach, Federal effort to support school health education have been largely categorical and uncoordinated since the abolishment in 1981 of the Office of Comprehensive School Health within the then-Department of Health, Education and Welfare. This subpart is intended to reverse the trend that began in 1981 and to promote cooperation and coordination between the health, human services and education programs available to school-aged children.

The committee intends that all Federal school health education grant programs, projects, and research efforts be coordinated through an inter-agency task force cochaired by the Assistant Secretary for Health, Department of Health and Human Services, and the Assistant Secretary for Elementary and Secondary Education, Department of Education.

The committee has directed the task force to submit a report to the Congress with recommendations regarding consolidation of Federal school health education initiatives. The committee believes that rather than perpetuating categorical programs, barriers should be removed to encourage States, local educational agencies, and local communities to address health-related problems in a coordinated and comprehensive manner. Instructive examples of such coordination are the Center for Disease Control and Prevention's administration of HIV education programs for school-aged children and the CDC's "Risk Behavior Survey," developed in cooperation

with a number of Federal, state, and private-sector entities, to gather information regarding the prevalence of those behaviors practiced by youth that put their health at risk. The task force is also asked to develop model students learning objectives and assessment instruments, in consultation with the National Coordinating Committee on School Health and other advisory bodies.

The Committee provides grants to State educational agencies to integrate comprehensive school health education programs in the State's public schools, grade K through 12. The committee anticipates that the office administering this grant program will be the focal point for school health education within the Federal Government and that a close partnership will be created with the Department of Education for coordination and implementation of school health education programs through States in local schools.

The committee requires the State educational agency to jointly develop and submit an application for these grants with the State health agency. The application must outline a State plan for comprehensive school health education; include measurable goals and objectives relate to comprehensive school health education programs and consistent with the Healthy People 2000 objectives and the National Education Goals; include information on how the State plans to coordinate the grant with other Federal, State, and local health education programs; and most important, describe input from the local community, including students and parents, in the development and operation of comprehensive school health education programs.

The committee intends that States, local educational agencies, and schools should have the ability to use grants funds authorized under the Department of Education's Safe and Drug-Free schools program and all other categorical school health education programs administered by Federal agencies as part of sequential age-appropriate, comprehensive school health education programs. This section authorizes the Secretaries of Education and Health and Human Services to grant waivers to States so that Federal school health education programs in elementary and secondary schools may be coordinated in a comprehensive manner. Testimony on the need for this explicit authority was received by the committee during the 102nd Congress. The committee recognizes that the High Risk Youth Program administered by the Center for Substance Abuse Prevention differs from other programs for which waivers are authorized to be granted. Unlike other programs for which waivers may be granted, this program is a competitive, discretionary demonstration program funding community based groups for preventive health activities in 5 year funding cycles. The committee intends the Secretary to grant waivers regarding this program only in situations where community-based grantees and the school health agency concur that addressing the needs of high risk youth can best be addressed through waiver of program requirements.

The committee has heard testimony regarding the need to disseminate school health education materials and technologies to educators, schools and involved community groups. At a committee hearing during the 102nd Congress, educators discussed some of the difficulties they encountered when seeking assistance or at-

tempting to locate health education materials developed with Federal support. The committee believes that information regarding educational material developed through federal grants and programs should be readily accessible, and has directed the Secretary to establish a national clearinghouse to provide a central reference point for available materials.

School health education

The committee unanimously supported school-linked and school-based health services as an essential health care delivery system to ensure access to basic health services among the school-aged population. The committee is aware of the advantages of providing health services in schools since children and youth spend much of each day there. The committee intends that school health services supported under this title be easily accessible and provided in an age appropriate manner. The committee views nonfinancial barriers, such as transportation, long lag times for appointments, and fears about confidentiality which easily discourage adolescents from seeking care at more traditional locations, as detrimental to improving students' health. The committee places importance on linking school health services to other community resources of care in order to assure continuity of care during nonschool hours and for those services not provided through the school.

The committee intends that grants made under this title for the planning and operation of school health centers shall support the delivery of a broad range of services. The committee recognizes the unique nature of each community and the importance of local determination regarding those services to be provided on site. However, the committee has also heard serious frustrations from local service providers regarding the categorical nature of Federal funding. The committee intends that the funds under this subtitle coordinate, colocate or provide directly a variety of services responsive to the varying needs of the children and youth to be served. The committee encourages grantees to establish broad-based local partnerships to augment health services with other community youth development and vocational resources to provide students additional opportunities to build self esteem, achieve academic success and explore career options. The committee does not intend for these funds to be used for construction.

The committee recognizes that funds available under this subtitle are inadequate to address the need for school health services across the nation. Given limited resources, the committee intends the Secretary to give priority to those communities which reflect the most substantial level of need for health services among their school-age population. The committee intends the Secretary to consider such factors as high rates of children in poverty who lack adequate access to health care, adolescent pregnancy, sexually transmitted diseases including HIV, youth violence, school drop-outs, and alcohol or other drug use.

SUBTITLE L—FULL FUNDING FOR WIC

This provision achieves full funding for the Special Supplemental Food Program for Women Infants and Children through the year 2000.

This provision sets target levels for WIC appropriations, based on the President's 1995 budget proposal and adjusted annually for inflation. Additional funds are authorized so that the total funding is enough to serve every eligible woman, infant, and child in the WIC program.

WIC, which celebrates its 20th birthday this year, feeds hungry infants and children, prevents low birthweight, reduces anemia and increases childhood immunizations. WIC ranks among the most successful nutrition and health programs anywhere.

Investment in WIC produces immediate savings in Federal health care spending. Every dollar spent on WIC to improve the health and nutrition of a pregnant woman can save 3 dollars in medical costs later on.

Savings are generated when fewer newborns need emergency, intensive medical care. Low birthweight infants are at greater risk to developmental handicaps, birth defects, infectious diseases, behavior problems, and other complications.

A 1992 General Accounting Office report (*Early Intervention: Federal Investments Like WIC Can Produce Savings*) showed that WIC reduces the incidence of very low birth weight by 44 percent. GAO calculated that the Government investment paid for itself within a year—and averted \$1 billion more in medical expenses through the age of 18.

There is growing evidence of the benefits of breastfeeding in improving the growth and development of infants and in preventing a number of common health problems. The committee notes that breastfeeding promotion efforts in the WIC program have succeeded in increasing rates of breastfeeding. This experience with the WIC program demonstrates the effectiveness and value of breastfeeding education during pregnancy and breastfeeding support after birth. The committee encourages efforts in the training of health professionals and in the delivery of services covered under this act that will promote improved rates of breastfeeding among all women and babies in the nation.

SUBTITLE M—BORDER HEALTH IMPROVEMENT

The border between the United States and Mexico is undergoing unprecedented population growth and industrialization. This development has intensified the potential for serious health problems that the United States and Mexico will confront. The United States-Mexico Border Health Commission would provide for a coordinated bi-national strategy to identify, evaluate, resolve and prevent these health problems.

TITLE V

SUBTITLE A: QUALITY

Since monitoring and improving quality of care is essential, this bill establishes the National Quality Council, an independent council of experts, providers, and consumers to assist the National Health Board on quality issues and to ensure that quality is protected. The committee intends that the Council officially reports to the National Health Board but the Council also has the authority

to make recommendations directly to the Congress, the Secretary and the Agency for Health Care Policy and Research in areas relating to quality of care.

The National Quality Council will oversee a performance based program of quality improvement designed to enhance the quality, appropriateness, and effectiveness of health care services and access to care for all Americans. The Council will specifically look at measures of care for the population at large and for subgroups that may be vulnerable to being underserved or inappropriately served.

The duties of the Council include developing national goals and performance measures of quality of health care services and procedures, health promotion and prevention, and access to care and appropriateness of care. In addition to developing goals and measures, the Council will oversee a variety of data collection efforts to evaluate the impact of this Act on the quality of health care services in the United States and the access of consumers to such services.

Today, consumers do not have adequate information to make decisions about selecting their health care providers or health plans. And the information they do have is often so confusing, consumers frequently give up. Often they merely rely upon word of mouth and recommendations of family and friends. The National Quality Council will oversee the development of a consumer-friendly report card to convey information on the quality of health plans. Enrollees will be able to use this information as a starting point from which to select health plans. In addition, some aspects of health care delivery are too complex for consumers to evaluate on their own.

Section 5002 of the bill requires the National Quality Council to develop a set of national goals and performance measures of quality for both the general population and for population subgroups defined by demographic characteristics and health status. Included among these subgroups would be populations of individuals with mental and physical disabilities or chronic conditions.

Included among the subjects on which the national measures will provide statistical and other measures are outcomes of health care services and procedures, health promotion, prevention of diseases, disorders, and other health conditions, and access to care and appropriateness of care. The committee intends for the national measures developed by the National Quality Council to be consistent with, to the maximum extent possible, effective measures that have already been developed by State or Federal entities with respect to health care. The committee expects that sufficient consumer survey and plan data will be collected and verified independently to provide for reliable and valid analysis.

The committee expects that the outcome data will be meaningful for persons with disabilities and complex or chronic health conditions. For example, health promotion and prevention measures should assess health promotion and prevention for persons with disabilities and chronic health conditions, such as promotion of maximum functional capacity or prevention of secondary disabilities or deterioration in functional capacity. Similarly, access measures should assess whether covered health services are made available to all enrollees in a timely manner, and whether the facilities

in which the services are rendered are accessible to individuals with disabilities.

Although it is important to measure outcomes for all enrollees, the committee recognizes that patients may have different outcomes from procedures depending on their underlying health status. The patient with a preexisting comorbid condition is more likely to die in heart surgery than the previous healthy patient, even when an equally appropriate operation is performed equally well. Thus when quality measures assess outcomes, such as death from surgery, the outcomes need to be risk adjusted. In the absence of such appropriate risk adjustment, providers will have a disincentive to provide care for those patients who are sickest. For example, knowing the outcomes of surgery they perform will be available to future patients and that their livelihoods may depend on it, surgeons may be less willing to care for patients who because of poor health status are least likely to survive surgery. While continuing to ensure and measure high quality care, outcome measures should be risk adjusted.

Other provisions in the bill require evaluations of health plans using the performance measures developed by the National Quality Council, including report cards. The committee intends that quality measures break down results for population subgroups defined by demographic characteristics and health status. For example, a plan may score well with regard to the average enrollee but score poorly with regard to enrollees with disabilities. Performance measures must disaggregate the data so that the poor performance with regard to a particular subpopulation is apparent to enrollees, potential enrollees, and monitors. To the extent that a plan is found to be underserving a population subgroup or otherwise failing to meet quality standards, the committee intends that the State level exercise their discretion to apply an appropriate corrective measure as described in subtitle C of title I, ranging from fines to corrective action plans to decertification. The committee intends that quality problems be addressed promptly and corrected promptly.

Section 5006 enables the National Quality Council to advise the Secretary and the Administrator of the Agency for Health Care Policy and Research on priorities for clinically relevant guidelines. In formulating their recommendations, the committee expects that the National Quality Council will examine the development, review, and updating of guidelines as they relate to vulnerable patient populations; including persons with disabilities, children, and the elderly. The committee believes that guidelines should be based on appropriate methods of measuring these population's health care with regard to age-appropriate standards for development and functioning, the distinctive epidemiology of physical and mental disorders, and other characteristics of these patient groups that distinguish their health care from that of the general population.

SUBTITLE B, PART 1—NATIONAL HEALTH CARE DATA NETWORK

In order to support a national health care system, and to promote higher quality and more cost effective health care while reducing the waste and inefficiency of the current system, the bill provides for the creation of a national health care data network.

The data network established under this subtitle will be implemented and operated through a private-public sector partnership. The committee has incorporated provisions of S. 1494, the Health Information, Modernization, and Security Act.

The committee intends that the network be national in scope and be capable of collecting, processing and disseminating necessary information to those who need it in a timely and accurate manner. For example:

Families will need adequate information to make informed choices among health plans and providers;

States, the Federal Government and the National Health Board will need reliable information to carry out their various functions including administering discounts, monitoring compliance with insurance reforms and requirements on health plans, employers and families, implementing the cost containment provisions of title VI, and assessing the overall success of the bill in reaching its goals;

Health plans will need reliable information to continuously improve quality and promote cost-effectiveness;

Researchers in both the public and private sector and policy makers at all levels of Government will need data to set new priorities; and

The system as a whole will need extensive information to reduce waste and inefficiency in the delivery of health care.

Uniform national standards for data collection and reporting and the automation of much of this data form the basis of a national system for electronic data interchange.

The committee intends that standards developed with regard to State access to health care data through entities in the national health care data network be consistent with the health-related functions and needs of the State, including but not limited to public health, health plan and provider licensing and oversight, health planning, and cost containment.

SUBTITLE B, PART 2—PRIVACY OF INFORMATION

The committee has incorporated key provisions of S. 2129, the Health Care Privacy Protection Act, into the bill. The legislation is intended to establish privacy and security for protected health information. The bill establishes the principle that an individual's confidential health information is to be protected from unauthorized disclosure, and that when disclosures do take place, the scope of disclosure is to be limited to the minimum amount necessary to accomplish the purpose for which it was received. Civil penalties, a private right of action and criminal penalties are included to enforce the privacy protection provisions and to remedy invasions of health care privacy.

The committee provides a set of rules to govern patient authorization for disclosure of personally identifiable health information in order to make patient consent a meaningful and considered act rather than a routine requirement.

The committee also establishes limitations on disclosure made in the course of treatment and payment processes to the minimum amount of information necessary to fulfill the particular function. The bill also takes a functional approach to disclosures of protected

health information for purposes of treatment, payment, oversight, public health, emergency medical situations and health research. The bill specifies the responsibilities of those who create, collect, process, use and maintain protected health information. It also requires that security and integrity safeguards be utilized in connection with protected health information.

The bill establishes a set of patients' rights with respect to their health care records. These include a right of inspection, an opportunity to receive a copy of one's records, a mechanism to correct misleading or inaccurate entries, and a right to receive an accounting of the disclosures of protected health information that are made from one's records.

SUBTITLE C—REMEDIES AND ENFORCEMENT

The Health Security Act describes a set of rights and responsibilities applicable to consumers, health plans, States and the Federal Government, but the whole system depends on the enforceability of those rights and responsibilities. Subtitle C, which sets forth such enforcement remedies, is therefore a crucial component of the effort to reform the nation's health care system.

The enforcement of rights is especially important for consumers seeking health care services. In recent years, the absence of a comprehensive health care system that includes protections for consumers has led to growing numbers of problems and abuses. The committee has held several hearings and received hundreds of complaints from individuals wrongfully denied health benefits and unable to protect their rights under the current system.

In a managed competition environment, when plans are all obliged to provide a uniform benefit package at a fixed reimbursement rate, there is a financial incentive for plans to gain a competitive advantage by denying health care claims unfairly or prematurely. The committee has taken care to assure that consumers will be afforded a fair process for contesting the denial of health care services to which they may be entitled under the Health Security Act.

As the Supreme Court explained in *Goldberg v. Kelly*, 397 U.S. 254, 267 (1970), "[t]he fundamental requisite of due process of law is the opportunity to be heard. The hearing must be at a meaningful time and in a meaningful manner * * *. [T]hese principles require that a recipient have timely and adequate notice detailing the reasons for a proposed termination, and an effective opportunity to defend by confronting any adverse witnesses and by presenting his own arguments and evidence orally."

Accordingly, under this subtitle, when a consumer submits a claim for services or, in the case of a fee-for-service plan, a claim for reimbursement of services already provided, the health plan or its affiliated provider must respond within 15 days if it intends to delay, deny, reduce or terminate any service (including a referral). The notice would be written in language easily understood by an average enrollee in the health plan. This requirement is similar to existing requirements under Federal and State law.

The committee is concerned that consumers who do not speak English are provided with meaningful notice under this subtitle. In setting standards for such procedures, the Secretary of Labor

should consider adopting measures similar to those being considered by the Office of Civil Rights for the Department of Health and Human Services that such notices be provided in a language other than English whenever such language is primary for 5 percent of the relevant population (either area residents or health plan enrollees) or 100 persons where the relevant population is less than 2,000.

The committee understands the term "linguistically appropriate" in section 5203 to mean that materials be written in the appropriate languages, as described above, and in the appropriate dialect of the language if such distinctions are needed to assure that the materials are comprehensible to recipients.

The committee was also mindful of the need to assure prompt resolution of claims for emergency services. While requests for preauthorization would not be required for emergency services, urgent care services could be subject to preauthorization, with claims automatically granted unless denied within 12 hours of submission. The committee intends that emergency services be defined as under the Medicare program.

The committee intends that the distinction between emergency and urgent care services be based on the immediacy of the consequences. Urgent care services would be those reasonably necessary to avoid serious jeopardy to the claimant's health (including severe pain), serious impairment to bodily functions or serious dysfunction of any bodily organ or part. Urgent care review would also apply when a health plan proposes to terminate services involving the requisite degree and immediacy of harm.

In such a case, the health plan would not be permitted to subject the complainant to potentially irreparable harm by terminating the service pending the hearing, but the hearing officer could make an appropriate disposition of the case at the hearing, before final issuance of a hearing decision, including immediate termination of the service (with a short stay of such termination permitting the complainant to seek a temporary restraining order in a court of competent jurisdiction).

Complaints under section 5202 could be filed by a person aggrieved by any action, inaction or practice that causes or consists of any delay or denial of benefits. For example, a plan's denial of a consumer's request for referral to a specialist might give rise to a complaint.

Except in cases where exhaustion of health plan remedies would be futile, inadequate or risk irreparable harm, such exhaustion would be required before filing a complaint.

It is the intent of the committee that such internal plan remedies shall not be unduly burdensome or result in undue delay. No health plan may require a waiver of the right to challenge a denial of benefits through the process described in this Act.

The committee anticipates that the process for filing complaints will be simple and accessible to laypeople. Of course complaints would be submitted in writing, under oath or affirmation, and would provide notice of the essential nature of the dispute. But in developing regulations providing for the orderly filing of complaints, the Secretary of Labor should take into account that most

complainants will not have the benefit of counsel and will often be unfamiliar with the complaint review process.

Section 5203 provides consumers with a choice—they may pursue complaints in a court of competent jurisdiction, in an Early Resolution Program or in a hearing in the Complaint Review Office. The Complaint Review Office is required to clearly explain to individuals the legal ramifications of each option. With respect to the administrative hearing process, complaints should be assigned to a hearing officer with reasonable promptness, consistent with uniform national standards established by the Secretary of Labor.

By the time a complaint reaches the Review Office, it will have already been considered within the health plan's internal review process. But the hearing officer would be the first impartial observer to consider the complaint, and his or her review would be on a nondeferential *de novo* basis.

The complainant would be permitted to offer supporting evidence through affidavits and live witnesses and to cross-examine adverse witnesses. The complainant might choose to be assisted by an attorney or other representative, but counsel would not be provided as a matter of right. Hearings would be conducted with relative informality. The hearing officer would reduce oral testimony to writing, hear argument and permit such further testimony as is appropriate.

The hearing officer would compel by subpoena the attendance of witnesses and the production of documents at any designated time or place. For example, the complainant could properly obtain discovery of his or her medical files and other potentially material evidence. In carrying out the duty to ensure full development of the record and fair evaluation of the issues, a hearing officer would be authorized to take necessary steps such as the appointment of an independent medical expert to assist the complainant.

In the case of an urgent care complaint, the Complaint Review Office would ensure that the hearing commences not later than 24 hours after receipt of the complaint, and that a decision is provided to the complainant within 3 days of the complaint's receipt. When such a complaint concerns a health plan's termination or reduction of services (which would not take effect before the hearing to prevent potential irreparable harm), this same timetable would be observed.

Prompt disposition of complaints is critical if this administrative process is to satisfy the needs of both consumers and health plans. Accordingly, this subtitle imposes on hearing officers the obligation to issue findings of fact and a final decision within 120 days of the assignment of the complaint. In the event that the Complaint Review Office fails to assign the complaint within the time limits set by the Secretary of Labor, the time between assignment of the complaint and issuance of decision would be reduced correspondingly, thereby assuring a uniform, prompt timetable for issuance of final decisions. Consumers have no control over delays in the assignment of hearing officers, and should therefore be held harmless from such delays.

If the hearing officer finds in favor of the complainant, he or she may order the offending party to cease any act or practice violative of this Act, to provide benefits due, to pay the complainant reason-

able prejudgment interest on actual costs in obtaining the services at issue, and to pay the complainant's reasonable costs associated with the hearing (including reasonable attorneys' and experts' fees). In addition, the hearing officer may order any other appropriate relief, including injunctive and declaratory relief, and compensatory and punitive damages.

If the hearing officer finds that the complaint alleged no act or practice that violates the terms of the plan or the Health Security Act, the complaint would be dismissed. In addition, upon a proper finding that a complaint was entirely frivolous and devoid of any reasonable basis in light of the information known to the complainant and the complainant's circumstances, background and expertise, the complainant could be ordered to pay the reasonable costs (including, in an appropriate case, reasonable attorneys' and experts' fees) incurred by the party named in the complaint.

While claims that are clearly and entirely frivolous should be discouraged, consumers with claims they reasonably believe are legitimate should not be deterred from pursuing a complaint based on fear that they may be ordered to pay the costs and fees for a health plan or provider. Accordingly, the committee intends that the fees and costs should be assessed against consumers only in cases involving unequivocally frivolous claims.

Section 5205 establishes the National Health Plan Review Board. The Secretary of Labor, in consultation with the National Health Board, would establish rules governing the transactions of the Review Board, including reasonably prompt time limits after which, unless affirmatively overruled by the Review Board, hearing decisions would become final.

While Medicare principles would be observed in determining the amount in controversy, a \$10,000 jurisdictional limit would apply to cases brought before the Courts of Appeals, rather than the \$1,000 jurisdictional limit for cases brought to U.S. District Court under the Medicare statute.

Section 5237 establishes a private cause of action in an appropriate State court or Federal district court based on the failure of a consumer purchasing cooperative, large group sponsor or health plan to carry out a responsibility applicable under this act, whether by Federal statute, rule or regulation or State enactment.

As a general rule, exhaustion of administrative remedies would be required. In addition to the traditional exceptions to the requirement of exhaustion of administrative remedies (such as futility or inadequacy of remedy, and the risk of irreparable harm to the plaintiff), this provision establishes statutory exceptions to the exhaustion requirement as to disputes in four areas: status as an eligible individual; eligibility for a premium discount; eligibility for reduced cost-sharing; and enrollment or disenrollment in a health plan.

In an action under this section, the court may order any appropriate relief, including injunctive and declaratory relief and compensatory and punitive damages. The court may also award a prevailing party, especially a party whose claim or action is a significant factor in changing the defendant's policy or practice, reasonable attorney and expert fees as part of the costs. In making such determinations, the committee intends that courts use the prin-

ciples applicable to civil rights plaintiffs under 42 U.S.C. 1988. See, *Hensley v. Eckerhart*, 461 U.S. 424 (1983).

SUBTITLE D—MALPRACTICE REFORM

The committee is skeptical of the claim that medical malpractice liability contributes significantly to spiraling health care costs. According to the congressional Office of Technology Assessment, "[t]he direct costs of malpractice, measured by insurance premiums paid by physicians, hospitals, HMOs and other providers account for less than one percent of the health care budget." "Impact of Legal Reforms on Medical Malpractice Cost," OTA-BP-H-119 (Washington, DC: US Government Printing Office, October 1993) (hereinafter "1993 OTA Study.") And while malpractice may contribute to the practice of "defensive medicine," that phenomenon has not been impartially measured. What may seem to some as unnecessary defensive medicine may seem to others as the sound exercise of care and medical judgment.

The committee was also wary of violating principles of Federalism in crafting malpractice liability reforms. Tort law has traditionally been a matter of State prerogative, and the committee debated at some length the dangers of preempting carefully considered State laws in a field in which State legislatures have been active. Where the committee adopted preemptive language, it generally chose to do so evenhandedly, preempting State laws that were more favorable to consumers as well as those more favorable to health care providers and insurance companies.

But despite its skepticism about the impact of malpractice reforms on medical cost containment, and its belief that the Federal Government has only a minimal role in improving State civil justice systems, the committee sought to craft a package of reforms to provide for fairer and more expeditious resolution of malpractice disputes. The committee was largely guided by the recommendations of the Clinton administration in this task.

Alternative dispute resolution

The centerpiece of both the Administration's malpractice reform proposals and the Committee's malpractice subtitle is the requirement that states adopt at least one alternative dispute resolution model developed by the National Health Board pursuant to section 5302.

The committee finds that alternative dispute resolution (ADR) can be an appropriate and efficient tool in the resolution of medical malpractice claims, but safeguards are necessary to ensure that claims are resolved in a fair and neutral fashion. Section 5302 is carefully crafted to encourage the timely and efficient resolution of medical malpractice claims, yet at the same time provide the necessary protections to preserve fairness and due process.

For example, it is critical that the entity administering an ADR mechanism be neutral and unbiased. If the administering entity has a financial interest in the outcome of the proceeding or is otherwise favorably disposed towards one party or the other, the credibility of the whole process is jeopardized. For this reason, the committee has rejected the Administration's proposal to place responsibility for establishing and maintaining the ADR process in the

health plan. Rather, the committee has assigned this task to each state.

Under section 5302, states must choose one or more ADR procedures from a "menu" of procedures established by the National Health Board. The Board, in turn, must assure that all of the procedures on the menu satisfy basic standards of fairness and efficiency.

First, each alternative dispute resolution mechanism adopted by the States (except voluntary binding dispute resolution for small claims) must be nonbinding and allow for unfettered access to the civil justice system upon completion of the alternative dispute resolution procedure. Without this vital guarantee of the ability to seek further redress, any alternative dispute resolution mechanism would be vulnerable to a constitutional challenge based on an abrogation of an individual's Seventh Amendment right to a jury trial.¹

Furthermore, the phrase "damages or other redress * * * otherwise permitted under State law" in subsection 5302(d) is evidence of the committee's intent that plaintiffs be allowed to pursue any avenue of further legal redress that might be available at the State level. The phrase is not intended to encourage states to limit the rights of plaintiffs to seek further judicial redress. It is the committee's intent that any plaintiff dissatisfied with the outcome of ADR retain access to the courts.

The committee also believes that the results of ADR and any statements, offers, or other communications made during the proceeding should remain confidential and be inadmissible at any subsequent trial. If ADR is to work properly and be anything more than a pro forma procedural step on the path to the courtroom, the parties must be able to deal with one another in an open and confidential manner. Experience at the State level and with the Federal Rules of Evidence teaches that nothing meaningful will be accomplished if the parties are constantly worried that what they say or do during the ADR process will come back to haunt them at a subsequent trial.

Nonetheless, in recognition of federalism concerns, the committee accepted an amendment offered by Senator Coats that permits states such as Indiana to maintain laws or rules of evidence that make ADR results or statements admissible at trial. In the absence of State laws on this subject, confidentiality will be maintained.

Alternative dispute resolution has proven to work best in the states after a malpractice claim has been filed and a reasonable opportunity for discovery has been granted. Both parties have a stronger incentive to negotiate in good faith once an action has been filed, and reasonable discovery provides the parties with the information they need to make the ADR process meaningful.²

In Section 5302(a), the committee recognizes that ADR may occur "prior to" initiation of a malpractice action, but expects that in

¹ In its recent comprehensive study on the issue of medical malpractice reform, the Office of Technology Assessment concluded that "it is difficult to make alternative dispute resolution (ADR) procedures binding and mandatory without running afoul of constitutional protections such as the right to trial, equal protection, access to courts and due process." 1993 OTA Study, *supra*, at 101.

² Conducting alternative dispute resolutions after a period of discovery "balances the interest in early intervention with the interest in having the dispute sufficiently developed, so that a valid decision on the merits can be made." Metzloff, Thomas B., "Alternative Dispute Resolution in Medical Malpractice," 9 Alaska Law Review 429, 452 (1992).

most cases, ADR will occur after the filing of an action when it will be most effective.

The committee bill requires that the Board establish at least the following models: arbitration, voluntary binding arbitration for small claims, mediation, early neutral evaluation, and a certificate of merit requirement.

"Arbitration" means an adversarial procedure during which a neutral decision-maker hears evidence presented by the parties and then makes a nonbinding ruling as to facts, law, liability or damages. Arbitration should be court-annexed or otherwise overseen by the court to provide adequate protection for the parties.

"Voluntary binding arbitration" is intended to encourage compensation for the large number of small claims not adequately addressed under the current system. It is the sole exception to the rule that parties dissatisfied with the ADR outcome may seek further judicial redress. But because it is binding, this form of ADR must be strictly limited to cases involving a small amount of money that might typically be found in small claims court. Binding arbitration may only occur with the voluntary consent of the plaintiff, and consent should not be considered voluntary if the plaintiff was compelled or in any way persuaded to grant consent to binding arbitration as a prerequisite to the provision of medical treatment or insurance coverage.³

"Mediation" is fundamentally different than arbitration in that it is nonadversarial and no decision is rendered as to facts, law, liability or damages. A neutral third party, or "mediator" brings the parties together and assists them in reconciling their differences so that a settlement might be reached. Like arbitration, however, a State mediation system must be court-annexed or otherwise overseen by the court to provide adequate protection for the parties.

"Early neutral evaluation" is a hybrid between arbitration and mediation. The parties present evidence to a neutral evaluator who has the qualifications and experience necessary to render an informed and unbiased assessment of the merits of the case. The evaluator offers an assessment of the merits of the case, and then the parties are encouraged to reach a settlement based on the assessment. This model has shown great success in resolving disputes in Federal district court in the Northern District of California, and in other jurisdictions that have utilized it.

"The certificate of merit" requirement is not traditionally categorized as an alternative dispute resolution mechanism, and indeed it was listed as a separate malpractice reform in both the Administration's bill and the Chairman's Mark. During consideration of the bill, however, the committee agreed to an amendment offered by Senator Hatch to strike the certificate of merit as a separate requirement and instead to permit it as one way a State might satisfy its obligation under section 5302.

Several states already deter frivolous lawsuits by requiring that a plaintiff submit an affidavit and a written report from a qualified expert attesting that the claim is not frivolous. The committee has

³The committee agrees with the Office of Technology Assessment that "contracts between two parties may be held unenforceable if the bargaining power of the parties is disparate and the party with the greater power unfairly limits the rights of the weaker party." 1993 OTA Study, *supra*, at 53.

included this option under section 5302 with the expectation that the Board will set standards for determining who is "qualified specialist" and when the identity of a qualified specialist may be shielded from the defendant similar to those originally contained in the Chairman's Mark. Typically, such specialist will be granted immunity from liability from the preparation of the written opinion, and the plaintiff will be granted an extension of the time for submission of the certificate for good cause.

Finally, it is unwise and ineffective to have a health care specialist make a legal conclusion as to the legal "merits" of the claim. Because the rationale behind the certificate of merit requirement is to eliminate frivolous lawsuits, the committee intends the term "reasonable and meritorious cause" be interpreted to mean that the specialist confirms that the claim is not frivolous based on the medical evidence presented.

Limits on attorney contingency fees

Both the Administration's bill and the Chairman's Mark proposed a 33⅓ percent limit on the amount of an attorney's contingency fee. The purpose of this proposal is to ensure that injured consumers receive no less than two-thirds of the compensation they deserve, while still ensuring that attorneys have an incentive to accept malpractice cases, including those in which recovery is uncertain.

During the committee's deliberations, it voted twice to lower the limit below 33 and ⅓ percent. First it adopted an amendment offered by Senator Hatch to place the limit at 25 percent across the board. Then it adopted an amendment offered by Senator Metzenbaum to Senator Hatch's amendment. The effect of the Metzenbaum amendment is to limit the attorney's fee to 33⅓ percent of the first \$150,000 and 25 percent of amounts over \$150,000. This is embodied in section 5303 of the bill reported by the committee.

Due to the high costs associated with investigating and preparing medical malpractice cases, more extreme fee limitations may render many meritorious malpractice claims financially unfeasible and make it difficult for consumers with legitimate malpractice claims to obtain adequate legal representation. Moreover, extreme fee limitations have a disproportionately negative impact on the poor, the elderly, children, and other victims who may not be able to demonstrate a substantial economic loss.⁴

The contingency fee arrangement serves to level the playing field between wealthier defendants and more vulnerable plaintiffs by giving these victims of malpractice a chance to obtain the legal representation they need to receive fair compensation.

Collateral source reform

Section 5304 is intended to prevent "double recovery" by malpractice plaintiffs who receive both a malpractice award and collateral payments from, for example, an insurance policy or worker's compensation fund.

⁴Burstin, Johnson, et. al., "Do the Poor Sue More? A Case Control Study of Malpractice Claims and Socioeconomic Status." 270 *Journal of the American Medical Association* 1697 (1993).

However, the committee has modified the collateral source reform proposed by the administration in three important respects. First, the amount of the collateral source offset is to be reduced by the amount of the award that is subject to subrogation by the collateral source payor.⁵ When such subrogation occurs, the plaintiff does not receive "double recovery" and without such an adjustment, plaintiffs would unfairly be subject to a "double reduction."

Second, the amount of the collateral source offset is to be reduced by the total of any premiums that the plaintiff has paid to be eligible for the collateral source payment. Again, if the purpose of collateral source reform is to make sure that the plaintiff is not made more than whole, it is appropriate to calculate, for example, the insurance premiums that a plaintiff has paid over the years. Without this adjustment, responsible consumers who maintain insurance policies, including life insurance policies, would actually be penalized for their farsightedness.⁶

Finally, section 5304(b) provides that the court may reduce a subrogation lien by an amount representing reasonable costs incurred in securing the award subject to the lien or claim. When a collateral source holds a right to subrogation from an award received by the plaintiff and seeks to be reimbursed, it is the plaintiff who incurs the cost of securing funds for the benefit of the holder of the lien or claim. Thus, when a subrogation lien or claim exists and the holder of such lien or claim seeks to be reimbursed, the court must have the ability to reduce the amount of such lien or claim by the reasonable costs incurred by the plaintiff to obtain the award in the first place.

Periodic payment of awards

In section 5305 the committee bill permits courts to structure the periodic payment of future damages. The rationale for this provision is to relieve the burden of malpractice awards on health care professionals and their insurers in appropriate circumstances. Section 5305 is carefully drafted to accomplish this goal without infringing upon the rights of plaintiffs to receive just compensation or unnecessarily hindering a court's discretion to require or modify a periodic payment schedule based on the equities of each individual case.

For example, if a victim's injuries should suddenly result in unforeseen medical problems, the victim must have access to the future damages payments to meet these circumstances. Such flexibility is absolutely essential to achieve fairness for both plaintiffs and defendants in medical malpractice actions.

Periodic payments must be limited to future damages to assure that victims of malpractice receive adequate funds to cover the often substantial debts and out-of-pocket costs that accrue during the immediate period following their injury and resolution of their claim. In addition, courts must have the discretion to require that the defendant purchase an annuity or other security interest as a necessary safeguard that the defendant is properly situated to comply with the relevant payment schedule. Another crucial measure

⁵ Such rights of subrogation are common. 1993 OTA study, *supra*, at 33.

⁶ Branton, "The Collateral Source Rule," 18 St. Mary's Law Journal 883 (1987).

of protection in this section is the ability of the plaintiff to petition the court for a lump sum payment discounted to present value should the defendant fail to make payments in a timely manner or become insolvent. The plaintiff should not be forced to bear the risk that a defendant will be unwilling or unable to make the required payments.

State malpractice reform demonstration projects

The committee has authorized the Secretary of Health and Human Services to award grants to states to establish "State Malpractice Reform Demonstration Projects" in order to assess the fairness and effectiveness of one or more of the following medical malpractice liability systems: (1) no-fault liability; (2) enterprise liability; and (3) practice guidelines. The committee expects these demonstrations to examine the impact of each of these models on:

- (1) The incidence and prevention of medical negligence;
- (2) The costs associated with medical negligence;
- (3) The patterns of medical malpractice litigation;
- (4) The patterns of malpractice insurance costs; and
- (5) The effect on compensation to victims.

Because these systems have not been tested as state-wide systems of liability, it is vital that the Secretary of HHS promulgate regulations that protect consumers within these projects. Therefore, the Secretary must ensure that the project will not deny due process to injured plaintiffs before awarding grants under section 5311.

No-fault liability

Critics of the tort system have promoted an alternative no-fault approach: a medical malpractice liability system based on causation rather than fault. Under a no-fault system, negligence is eliminated as a criterion and some or all injuries caused by medical care would be compensated as determined by the parameters of the no-fault program. The no-fault approach seeks to compensate as many victims as possible for harm resulting from medical care.

The committee intends that the Secretary carefully clarify and delineate the parameters of coverage as well as the claim procedures for medical adverse events caused by medical management under section 5311(b)(1). The Secretary should also examine the experience of the Virginia and Florida no-fault impaired infant systems, which have not proved very successful, in order to improve the proportion of victims compensated and to assure that concurrent quality control systems are integrated to minimize physician error.⁷

Moreover, before approving any no-fault demonstration project, the committee requires that the Secretary determine that under

⁷ Currently, Virginia and Florida are the only states with no fault medical liability systems. Both of these systems are limited to "Impaired Infant Funds" which address only specific narrow, adverse clinical outcomes. For example, the Virginia impaired infant fund addresses birth-related injuries with brain or spinal cord damage, which injury was caused by a deprivation of oxygen in the course of the delivery and was not caused by a congenital or genetic factor, but which has rendered the infant permanently disabled in all activities of daily life. 1993 OTA Study, *supra*, at 43. These funds have had only limited impact: only 5 claims have been accepted and paid under the Virginia plan since 1987 and only 23 claims have been accepted and paid under the Florida plan (Jan. 1988-July 1993), according to the National Center for Patients Rights.

section 5311(c)(3)(E), the following considerations have been satisfied:

(1) *Due Process and Access to the Courts.* Although the bill defines "no-fault liability system" as a "system established by a State receiving a grant under this section which replaces the common law tort liability system for medical injuries," the no-fault system need not create barriers to trial by jury for participants.

If a person has been injured by an adverse event as a result of medical management which is covered by the Act, a claim must first be adjudicated through the State no-fault compensation program before filing a civil action in the courts.

Should a petitioner choose to reject the finding of the administrative body authorized to review her claim, he or she must be left free to pursue whatever additional remedies may be available to her under applicable law. Of course if the petitioner chooses to receive compensation from the State administrative body, he or she may not bring a civil action for damages against the defendants in the no-fault procedure.

(2) *Statute of Limitations.* Should the petitioner choose to file a civil action for damages, he or she must look to State law for the period within which such an action for damages must be filed. The filing of a petition for compensation with the State no-fault system should stay the statute of limitations during the pendency of the petition for compensation under the State no-fault system.

(3) *Accountability and Deterrence of Medical Malpractice.* While the tort system holds doctors accountable for their behavior in addition to compensating individuals who have been harmed, the no-fault system may remove personal responsibility for negligent behavior and mask the occurrence of negligent medical treatment.

In order to ensure that no-fault liability systems do not frustrate the regulation and discipline of negligent health care providers, all cases reported to the State administrative body authorized to administer the no-fault project should be reported to the State medical board and the Department of Health, which have licensing and disciplinary authority over physicians.

The State medical board should investigate any evidence which appears to show that a health care professional is or may be medically incompetent, has engaged in unprofessional conduct, or is mentally or physically unable to engage safely in the practice of medicine. The State medical board must examine the patterns of claims brought and develop professional standards to address the occurrence of medical negligence.

The committee notes that since no more than 10 percent of the amount of each grant can go for administrative costs, the Secretary must carefully examine the increase in the number of "adverse events" which will be eligible through a no-fault compensation system and factor in the administrative costs of a State administrative body to review these claims. Although a no-fault system removes the required showing of "fault," the claimant must still make a showing of "causation." The administrative costs of a system which still requires a showing of causation and which may significantly increase the number of adverse events reviewed, may result in costs which far exceed those of the tort system.

The committee underscores that section 5311(e)(2)(B), Waiver of Cost Limitations, does not alter the requirement that no demonstration project shall be implemented unless adequate funding is appropriated.

The committee believes that section 5311(f)(5)(B) is extremely important in order to gain national data on the efficacy of these alternative liability programs. Each State is required to submit an annual report to the Secretary which shall include, "the extent to which the system exceeded or failed to met relevant performance standards including compensation for and deterrence of medical adverse events."

Enterprise liability

Enterprise liability shifts liability for physicians' negligence onto the institutions which employ them and thereby relies on institutional risk management and regulation to address negligence. According to its proponents, the oversight of medical care by hospitals and HMOs will be sufficient to offset the reduction in personal accountability inherent in an enterprise liability scheme.

The committee believes that enterprise liability can help reform the malpractice system, but wants to ensure that it does not undermine accountability and deterrence of negligent medical care. In order to address this concern, under Section 5311(c)(3)(E), the Secretary should consider the following factors in awarding enterprise liability demonstration projects:

(1) *Standard of Liability.* While doctors are usually held to a high national standard of care, the Secretary must assure that hospitals and HMOs are not granted a lower standard under enterprise liability. It should be clear that when a doctor is alleged to have committed malpractice, the lawsuit will proceed under traditional substantive and procedural rules for physician liability, even though the entity being sued is the hospital or health plan.

(2) *Accountability and Deterrence of Medical Malpractice.* The committee realizes that by removing doctors from liability in medical malpractice lawsuits, enterprise liability may weaken incentives to practice safe medicine. The theory behind enterprise liability is that the oversight of medical care by hospitals and HMOs will be sufficient to offset this reduction in personal accountability. To protect quality, an enterprise liability system should also have a strong system for disciplining doctors who practice substandard or negligent medicine.

(3) *Malpractice Insurance.* Health plans and hospitals which are to be liable for all the malpractice committed by their doctors, must be required to carry sufficient insurance to cover their liability. The Secretary should establish standards on the minimum mandatory amount of liability insurance to be carried by the enterprise.

Practice guidelines

The committee has modified the practice guideline reform proposed by the administration in that the practice guidelines will be used in medical malpractice actions to establish a rebuttable presumption regarding medical negligence for either the plaintiff or the defendant. Practice guidelines must be admissible for both ex-

culpatory and inculpatory purposes in order to guarantee fairness to both parties in a malpractice action.

Caps on damages

During consideration of the bill, the committee rejected amendments that would have limited punitive and noneconomic damage awards in medical malpractice actions.

Members of the committee noted during the debate that imposing Federal "caps" on damages in medical malpractice actions would interfere with the statutory and common law prerogatives of the states. Some states have chosen to cap damages (and the committee explicitly chose not to preempt such laws), but the committee did not identify a compelling need to Federalize this aspect of tort law.

This is especially true with respect to punitive damages, because they are rare in medical malpractice cases. A study by the American Bar Foundation of 25,627 jury verdicts between 1981 and 1985 from 47 counties in eleven states found that punitive damages were awarded in only 2.9 percent of the medical malpractice cases.⁸

Committee members also expressed concern about the impact on women of capping punitive damages. Women are twice as likely to qualify for punitive damages than men, according to a recent estimate. Women outnumber men in four areas of wrongdoing by health care providers that give rise to punitive damages: sexual assault, intentional torts such as fraud or false imprisonment; extreme violation of medical standards of care; and abandonment, neglect or failure to treat a patient. Women are almost exclusively the victims of sexual abuse by providers, for example. Therefore, the burden of limiting the availability or amount of punitive damage awards would fall disproportionately on women.⁹

The committee also declined to adopt an amendment to cap non-economic damages. In addition to the federalism objections previously noted, the committee questioned the fairness of such caps. Non-economic damages compensate patients for financial loss. Injuries resulting in disfigurement, the inability to give birth to a child, or the loss of the use of a limb, for example, cannot be measured solely in terms of lost wages or other such economic calculations. Non-economic damages provide the individual with some compensation for the genuine suffering that often accompanies malpractice injuries.

Caps are fundamentally unfair in that they deny full recovery only for severely injured patients whose damages exceed the cap while permitting complete recovery by those with lesser injuries. Thus, the more severely injured patients bear the cost of the caps, while negligent providers gain the benefits.

Members of the committee also noted that caps on noneconomic damages have a disparate impact on women, minorities, lower income, elderly and young patients. Women, for example, generally recover less than men for equivalent injuries in medical malpractice actions because they suffer lower economic losses. This re-

⁸Daniels & Martin, *Myth and Reality in Punitive Damages*, 75 Minn. L. Rev. 1, 38 (Tbl. V) (1990).

⁹Koenig & Rustad, "His and Her Tort Reform: Gender Injustices in Disguise," Delivered at the Annual Meeting of the Law and Society Association, at 87 (Phoenix, AZ, June 18, 1994).

flects the general disparity between men and women's incomes and occupational status. In Indiana, for example, where total damages are capped, a recent study found that the mean total award for men was \$157,709 and for women it was \$114,118—a highly significant difference.¹⁰

Since a greater proportion of women's recoveries are for non-economic losses, capping such damages would reduce a greater proportion of their recoveries. This same principle applies to the other groups of lower-income or unemployed patients.

In addition to these inequities, caps on noneconomic damages have not proven to provide significant cost savings in terms of overall health care spending. In California, a State that has a \$250,000 cap on noneconomic damages, the medical consumer price index has grown faster than in the Nation as a whole. The State had the second highest per capita health care costs in the Nation in 1990. The principal effect of caps has been to shift costs away from negligent providers in the form of lower premiums and impose costs on injured patients in the form of reduced recoveries.¹¹

Caps are not realistic or effective means to contain health care costs, since malpractice insurance premiums paid by doctors and hospitals in 1991 were approximately 0.6 percent of the total health care spending in the United States.¹²

Malpractice liability and litigation have a deterrent effect, thereby raising the quality of care and reducing the number of negligent adverse medical incidents. Caps would reduce providers' liability exposure, therefore reducing this deterrent effect and leading to an overall increase in such incidents.¹³ Not only would this increase unnecessary suffering, but it also would add costs to the health care system for the care of the additional injured patients.

The perception persists that jury verdicts for medical malpractice claimants are excessively high, but data from recent studies suggest that this is not the case.¹⁴

SUBTITLE E: EXPANDED EFFORTS TO COMBAT HEALTH CARE FRAUD AND ABUSE

Fraud and abuse is rampant in our health care system. It is draining an ever increasing amount from American families, businesses and the government. The Department of Justice and others have estimated that as much as 10 percent of national health care expenditures are lost to fraud and abuse. So as much as \$100 billion will be unnecessarily added to the nation's health care costs by fraud and abuse.

¹⁰ Kinney, Gonfein, & Gannon, "Indiana's Medical Malpractice Act: Results of a Three-Year Study," 24 Ind. L. Rev. 1275, 1288 (1991).

¹¹ Hearings Before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, 103rd Cong., 1st Sess. 218 (1993) (testimony of Walter H. Beckham, Jr., Member, Special Comm. on Med. Prof. Liability, ABA).

¹² "Medical Malpractice Insurance: 1985–1991 Calendar Year Experience," National Insurance Consumer Organization, (March 1993).

¹³ See, Hearings Before the Subcommittees on Health and the Environment, and Commerce, Consumer Protection and Competitiveness, U.S. House of Representatives, 103rd Cong., 1st Sess. (Testimony of Troyen Brennan, MD, JD, Harvard School of Public Health) (unpublished) (Nov. 10, 1993).

¹⁴ Vidmar, "The Unfair Criticism of Medical Malpractice Juries," 76 *Judicature* 118, 119–20 (Oct./Nov. 1992); Vidmar, "Empirical Evidence on the Deep Pockets" Hypothesis: "Jury Awards for Pain and Suffering in Medical Malpractice Cases," 43 *Duke L. J.* 217 (1993).

Reports by the General Accounting Office, Health and Human Services Inspector General, congressional committees and others have documented the extent and range of health care fraud and abuse. They have detailed abuses ranging from providers billing for millions of dollars of health care services that were never provided, to selling sham health insurance to unsuspecting small businesses struggling to afford coverage, to the illegal sale of controlled substances, these acts not only rob payers of billions of dollars every year, they also tarnish the good name of the vast majority of health care professionals and companies which are honest and providing quality services and reduces consumers' confidence in the health care system.

Health care reform, therefore, must include a comprehensive program to expand efforts at combatting health care fraud and abuse. The committee has included such a program.

PART 1. IMPROVED ENFORCEMENT

All-Payer Health Care Fraud and Abuse Control Program

Sec. 5401—The Secretary of the Department of Health and Human Services (hereafter referred to as the "Secretary") and the Attorney General are required to jointly establish a national all-payer program to combat health care fraud and abuse that coordinates Federal, state, and local law enforcement programs to control health care fraud and abuse; conducts investigations, audits, and inspections related to the control of health care fraud and abuse; and facilitates enforcement of this subtitle and others statutes applicable to health care fraud and abuse.

In carrying out this program, the Attorney General and the Secretary must carry out enforcement activities, have access to all records of health plans and consumer purchasing cooperatives and issue advisory opinions, fraud alerts, and other appropriate educational materials to assist in compliance with the provisions of the subtitle. The committee believes that an approach that balances increased enforcement authority and activities with increased educational information to providers and consumers is appropriate. The provision of such educational materials should be designed to increase compliance with the provisions of this subtitle and enhance appropriate enforcement. The provision does not require the Secretary or the Attorney General to respond to every request to provide advisory opinions, but to provide such opinions as appropriate in order to increase compliance. The issuance of advisory opinions under this provision is intended to be consistent with the 11 advisory opinion processes under other federal laws.

Establishment of all-payer health care fraud and abuse control account

Sec. 5402—An effective program to combat health care fraud and abuse must be adequately funded. Existing funding for such activities by the Secretary and the Attorney General would not be adequate to meet the increased responsibilities required by this subtitle. To supplement regularly appropriated funds, a special account would be established. All criminal fines, penalties, and civil monetary penalties imposed for violations of fraud and abuse provi-

sions of this subtitle would be deposited into the account and used for carrying out the requirements of this subtitle. In order to assure a balanced program, 20 percent of account funds would be required to be used for provider and consumer education, including advisory opinions.

Use of funds by inspector general

Sec. 5403—The Inspector General is authorized to receive and retain court awarded restitution for the costs of its investigations.

Reward for information leading to prosecution and conviction

Sec. 5404—The committee believes that an effective program to combat health care fraud and abuse must include the active involvement of consumers and others in the private sector. Consumers can and should play a critical role by providing authorities information about suspected abuse. In order to enhance enforcement, in some extraordinary instances it may be helpful for a reward to be provided for information leading to a health care fraud conviction. Accordingly, the Secretary and the Attorney General are authorized in special circumstances to jointly offer a reward of up to \$10,000 for information related to the possible prosecution of a health care offense. The provision strictly limits who would be eligible to receive such an award and contains provisions to assure against misuse.

PART 2. CIVIL PENALTIES AND RIGHTS OF ACTION

Civil monetary penalties

Sec. 5411—The Secretary and the Attorney General should have an appropriate mix of criminal and civil penalties to combat health care fraud and abuse. This section provides the Secretary authority to impose civil monetary penalties and exclude providers from participating in all health plans in certain limited instances. Similar to the authority she has under the Social Security Act, the Secretary is authorized to impose civil monetary penalties up to \$10,000 for false or violative claims and \$15,000 for giving misleading information in the decision to discharge a patient. Recovered funds would be returned to health plans, with the remainder going to the fraud and abuse control account. The section also provides for appeal proceedings.

Permitting parties to bring actions on their own behalf

Sec. 5412—In keeping with the committee's belief that an effective program to combat health care fraud and abuse must include an active effort by the private sector, a private right of action in U.S. District Court is provided for health plans or large group sponsors. This right would be limited to those entities which suffer harm or monetary loss related to a health care offense of at least \$10,000 and inform the Attorney General, who then decides not to pursue action. Awards could include treble damages, attorney's fees and equitable relief; 20 percent of any award in excess of damages goes to the fraud and abuse control account (see section 5403). This provision in no way limits other rights of action of individuals

under State and Federal law, nor does it give Federal court jurisdiction over any State court claim.

Exclusion from program participation

Sec. 5413—The HHS Secretary would be required to exclude individuals or entities convicted after the effective date of this act of health care felonies, patient abuse, and substance abuse felonies, from participation in health plans for no less than 2 years. In order to assure that execution of this authority does not significantly harm public health, the Secretary is given authority to impose an appropriate alternative sanction in those cases. The Secretary would continue to have authority to order different periods of exclusion for other health care convictions. Notice of exclusion and hearings is provided for.

PART 3. AMENDMENTS TO CRIMINAL LAW

Health care fraud

Sec. 5421—This section defines the crime of health care fraud. It provides a penalty of up to 10 years in prison, or fines, or both for knowingly executing a scheme or artifice to defraud a purchasing cooperative, health plan, or other person, in connection with the delivery of health care benefits, as well as for obtaining money or property under false pretenses from a purchasing cooperative, health plan, or other person, in connection with the delivery of health care benefits. This provision amends Chapter 63 of Title 18, U.S.C. concerning mail fraud.

Theft or embezzlement

Sec. 5422—This provision provides for penalties of up to 10 years in prison, or fines, or both, for embezzlement, stealing or willfully and unlawfully converting assets, funds, or monies of consumer purchasing cooperative or health plans. This provision amends Chapter 31 of Title 18, U.S.C., concerning fraud and false statements.

False statements

Sec. 5423—This provision provides penalties of 5 years in prison, or fines, or both, for knowingly and willfully falsifying or concealing a material fact, or making a false or fraudulent statement or using any false writing knowing that it contains any false or fraudulent statement. This provision also amends Chapter 31 of Title 18, U.S.C.

Bribery and graft

Sec. 5424—This provision provides for 15 years imprisonment, fines or both, for offering or giving anything of value to a health care official, with the intent to influence the official's actions or decisions or duties, or to influence that official to collude, commit or allow any fraud on a consumer purchasing cooperative or health plan, or to induce the official into violating a lawful duty. It also provides the same penalties for a health care official who demands, seeks, receives or accepts anything of value the giving of which violates the previous provision. It also would provide for two years im-

prisonment, or fines, or both for promising, giving or delivering anything of value to a health care official for or because of any of the health care official's action, decisions or duties relating to a consumer purchasing cooperative or health plan.

Injunctive relief relating to health care offenses

Sec. 5425—This provision expands the scope of section 1345 of Title 18, by adding the commission or imminent commission of a health care offense. This provision of the code allows the Attorney General to commence a civil action to enjoin such violation.

Grand jury disclosure

Sec. 5426—This provision allows the disclosure by a Government attorney or a person privy to grant jury information properly disclosed under the Federal Rules of Civil Procedure of grand jury information to a Government attorney, for use in any civil proceeding relating to a health care offense as defined in Section 5402(d). This provision amends section 3322 of Title 18, U.S.C.

Forfeitures for violations of fraud statutes

Sec. 5427—Requires the court, in imposing sentence on a person convicted of a health care offense, to order the forfeiture to the United States of any property constituting or traceable to the gross proceeds obtained as a result of the offense. This provision would amend Section 982(a) of Title 18, U.S.C.

Amendment to Civil False Claims Act

Sec. 5431—This provision would extend the Civil False Claims Act to claims under the Health Security Act. The current False Claims Act only covers false claims against the Federal Government. This provision would extend that protection to all false claims against health plans.

The most important impact that this amendment will have is in the extension of the qui tam provisions to health care fraud. The qui tam statute allows private parties to bring an action against a person defrauding a health plan. The Government has the option of intervening and managing the litigation, or allowing the private party (known as the qui tam relator) to proceed. The relator receives a portion of the recovery from the suit, with the remainder going to the Government or to the plan. This is a substantial weapon against health fraud, since it allows persons with knowledge of a fraudulent scheme to bring suit against the wrongdoer.

PART 5. EFFECTIVE DATE

Sec. 5441—Provides for effective date of January 1, 1995.

SUBTITLE F

McCarran-Ferguson repeal for health insurers

The McCarran-Ferguson Act, which created the insurance industry's exemption from the antitrust laws, was passed in 1995. 15 U.S.C. section 1011 et seq. This exemption contains two important provisos: First, insurers must be regulated by State law in order to claim the exemption. Second, acts of coercion, boycott or intimi-

dation by insurers are not immune from antitrust prosecution. For health insurers there is an additional limitation that has been imposed by the courts. Specifically, in *Group Life and Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), the Supreme Court held that deals between insurance companies and health care providers, such as pharmacies, are not immune from antitrust prosecution under the McCarran-Ferguson exemption. That means that providers can sue health insurance companies under the antitrust laws for price-fixing or other anticompetitive business conduct.

Although the McCarran-Ferguson Act does not give health insurers blanket immunity from antitrust suit, it could shield certain anticompetitive conduct that could harm consumers. For example, price-fixing agreements among health insurers on premium levels could be immune from antitrust suit under this exemption. For that reason, the administration has called for its repeal in the health insurance industry. In written testimony submitted to the Senate Finance Committee on May 12 1994, Anne K. Bingaman, Assistant Attorney General for Antitrust, stated that the "current, broad immunity could allow health insurers to act anticompetitively and thereby interfere with the * * * goal of relying on competition between insurers to control health care costs."

To insure that no sector of the health care industry enjoys a competitive advantage due to special antitrust immunity, the committee adopted an amendment to repeal McCarran-Ferguson immunity as it applies to the business of health insurance. It is the intent of the committee that the "provision on health benefits" language in the amendment refers to the business of insurance as it relates to the provision of medical services by health plans. It is further the intent of the committee that this section does not apply to property-casualty lines of insurance or any of their products. For example, "provision of health benefits" for purposes of this section does not include medical benefits under workers' compensation or automobile insurance policies. The McCarran-Ferguson Act immunity would continue to apply to these and all other lines of property-casualty insurance.

TITLE VI

Sec. 6107—The committee intends for the Board, in its implementation of a method to apportion an area's aggregate collection shortfall under (c) across premium payers, to establish a blended rate (or such other mechanism) that provides appropriate incentives for plans to vigorously pursue collection of unpaid premiums in a manner that limits, to the maximum extent practicable, plans; incentives to avoid enrollees that appear to represent a high nonpayment risk.

Cost control for large group sponsors

Sec. 6135—The committee intends to exclude from premium limit expenditures made by large group purchasers for worksite-based wellness and treatment programs that are beyond the scope of the comprehensive benefits package.

Calculation and publication of general family share and general employer premium amounts

Sec. 6204—The committee intends that a notice of amounts owed or due to a family would also explain the family's opportunity for a fair hearing to contest the state's determination of amount owed or due, which would precede any collection efforts of amounts owed.

TITLE VIII

This title begins with subtitle E because subtitles A through D of the Health Security Act (as introduced by Senator Mitchell) are outside this committee's jurisdiction. The omission of these subtitles should not be interpreted as a lack of support for these areas of the Health Security Act.

TITLE X

Workers compensation

Subsection (a) of section 10000 specifies that the provisions of part 3 of subtitle B of title V (relating to the use of standard forms) and the provisions of section 1916(2) (relating to information regarding clinical encounters and other items and services provided by health care providers) are intended to apply to the provision of workers compensation medical services by health plans and health care providers in the same manner as they apply to the provision of services included in the comprehensive benefit package. The intent of this subsection is to ensure that data collected through the national health care data network established under title V does not arbitrarily exclude important and relevant information relating to occupational injury and disease.

Although title X was amended in committee to eliminate provisions in the Health Security Act, as introduced, which would have required that individuals entitled to workers compensation medical benefits receive their medical services through the health plan in which they are enrolled, the elimination of these provisions does not diminish the need for reliable data regarding the treatment of work-related injuries and illnesses. Workers, employers and insurance carriers who are choosing among plans and providers to provide workers compensation medical services need accurate information to enable them to make informed choices as to which plans and providers are likely to provide the highest quality care in the most cost-effective manner. Researchers and policy makers need access to data on work-related as well as non work-related injuries and illness to properly study and understand disease and injury mechanisms and to set public health priorities. Information that increases understanding of the relationship between illness and injury and work can also assist plans and providers in the recognition of occupational illnesses and injuries, enabling them to provide more effective treatment and prevention and to accurately allocate treatment costs between the regular health care system and the workers compensation system.

Subsection (a) provides for information regarding the provision of workers compensation medical services to be collected and reported in accordance with the same uniform national standards applicable

to the collection and reporting of information relating to other health care services.

Subsection (c) of section 10000 requires health plans and their providers to comply with existing legal duties and reporting requirements under State workers compensation laws and other Federal and State laws, including laws regarding the reporting of occupational injuries and diseases. This subsection is not intended to create any new duties or reporting requirements beyond those that may be applicable to plans and providers under other laws.

ADDITIONAL VIEWS OF SENATOR CHRISTOPHER J. DODD

Although I strongly support health care reform that assures all Americans guaranteed health care coverage and believe that the escalation of health care costs must be controlled, I have serious reservations about the major cost containment mechanism included in the Health Security Act—the premium caps. I also am concerned about the committee's approach to the handling of claims and the resolution of disputes. It is my hope that alternatives can be found in both these areas when we move to the Senate floor.

PREMIUM LIMITS ARE NOT A BACKSTOP

The claim that the premium limits established in the act serve primarily as a backstop measure is misleading. The act sets tight caps and imposes them in the early years of reform. They begin in 1996, and by 1998 limit the annual growth in the average health insurance premium to the general rate of inflation. Premiums for the entire health insurance market currently rise at an estimated average rate of 12 percent a year compared with general inflation of 3 percent.

Given that historical expenditure patterns are likely to persist into the early years of reform, the expenditure limits proposed in the act will bind in many if not all regions. Their characterization as a backstop will not hold. They will take effect and control the prices of health care. This concerns me because price controls in this country have not worked in the past.

Stuart Altman, Chair of the Prospective Payment Assessment Commission and a supporter of health care expenditure limits, wrote in "Health Affairs" this Spring that the caps seem "unrealistically tough." He contends that the public and private cost controls included in the Health Security Act would "shift the United States from being among the fastest growing health spending countries to one of the slowest. The average real growth in health expenditures per capita in the Organization for Economic Cooperation and Development (OECD) countries from 1986–1991 was 3.4 percent. The U.S. rate was 5.3 percent. The Clinton plan would bring the per capita U.S. growth rate down to slightly above 2 percent by the year 2000."

FORMULA-DRIVEN PREMIUM LIMITS AND QUALITY

I believe that legislating such a dramatic reduction in health spending is at best a naive approach to a very complicated issue. At worst the caps will have a chilling effect on patient care in this country and slow progress towards new and innovative treatments for disease.

A significant problem with formula-driven premium limits is that they will be set in the absence of reliable data. Today, there is no centralized repository for the information necessary to establish

targets. It is difficult to know where premiums should be during the early years of health reform. New populations will enter the private market and the system will be in flux as it adopts community rating and a number of other reforms.

Under the legislation, the National Health Board set a national baseline beginning in 1996 on current national expenditures for the standard benefit package. This first step could be problematic.

The Administration and CBO estimates of the cost of the standard benefit package varied by 15 percent. A national budget that over or underestimates the "real" baseline spending by 15 or 20 percent could severely distort the health care market and have a direct impact on patient care, when applied as hard caps at a state or regional level.

Ratcheting down spending through premium limits is likely to cause problems for patients and adversely affect quality of care. It is difficult to know how low premiums could be set without seriously damaging quality or compromising solvency. Formula-driven limits set by the Federal Government do not have a relationship to patient needs. The caps provide almost no flexibility to respond to changing health needs; they de-link promised benefit and the costs of providing those benefits.

CBO has also said that premium caps could be seriously disruptive. CBO released a study in September 1993, reporting that premium caps could have a detrimental effect on the quality of care. One key finding it reported was that "technological progress in health care would probably occur more slowly."

PREMIUM LIMITS WILL STIFLE MANAGED COMPETITION

In a system of managed competition, competing health plans will all have to negotiate the best rates possible to attract members. System savings occur in part because hospitals and physicians must either become more efficient in their delivery of care or accept lower earnings in order to obtain patients. I support the numerous provisions approved by the committee that encourage market-based solutions and greater competition in the health care system.

Government-set premium limits that severely tighten historical expenditures will serve in all likelihood as a price floor and ultimately stifle competition. The caps set forth in the act give health plans the incentive to bid cautiously high or right at the target level. Plans that bid low risk depleting their reserves if costs are higher than estimated in the early years of reform. Plans that price at the caps will be the easiest to defend before boards of directors. Bidding at caps ensures fiscal prudence and protects plans and providers from mandated premium reductions and insolvency.

Tight caps may also create barriers to entry for new plans. Plans that are initially more expensive would be frozen out of the market. A company that has new ideas for delivering care inexpensively but has high capital costs in the early years will not be able to bid at a level that brings them within the targets.

There are numerous examples of private and public entities that have demonstrated their ability to reduce the costs of health care without harm to quality; however, the savings have occurred through market-based solutions not by government-set limits on spending. Prices have come down in certain markets largely due to

aggressive purchasers, such as General Mills, and to the use of managed care.

An April 1994 Lewin-VHI study of network managed care showed savings of 23 percent over fee-for-service plans in 1992. The study is unique in that it controlled for risk benefit design and markets so that it provides the most accurate measure of managed care savings to date. In addition, the average increase in premium for HMO members in 1994 was 5.6 percent, down from 10.6 percent in 1992.

It is my view that CBO scoring prevented the committee from exploring less rigid alternatives to the premium limits. In its report on the Health Security Act, CBO scores the caps as 100 percent effective and bases its estimates of the bill on use of the premium caps, not on savings achieved through competition and managed care. This assumption has hindered our ability to explore alternatives.

CLAIMS AND REMEDIES

Although the way claims are handled and disputes resolved today is inadequate and should be addressed in the context of health care reform, the committee adopted an approach that invites individuals to bring lawsuits and seek punitive damages. Such an approach hurts rather than helps our effort to eliminate wasteful spending, control costs, and reduce unnecessary lawsuits.

During mark up of the bill, Senator Jeffords and I offered an amendment that would provide a new process for claims disputes and remedies, without encouraging needless causes of actions. The important elements of this amendment included: an expedited process to resolve claims quickly before there is a delay in treatment or payment; a uniform federal system to avoid the patchwork of standards created by state litigation; expanded damages for claimants under ERISA; a non-litigious process that would encourage early settlement of claims disputes; and a fast track process for urgent requests for treatment. The amendment failed.

It is my hope that when the Health Security Act reaches the floor of the Senate, we will find less onerous mechanisms for cost control and compromises in the area of remedies. I look forward to working with members both on and off the committee to find such alternatives.

ADDITIONAL VIEWS OF SENATOR PAUL DAVID WELLSTONE

I am proud of the health care reform bill the Labor Committee has produced. I believe it establishes some important programs that will make people healthier, and will improve health care services, ranging from extended support for public health priorities to the work we have done for people with mental and addictive disorders and victims of domestic violence.

The bill also sets a framework that will enable our nation, finally, to guarantee every American affordable coverage for comprehensive health benefits.

I would like to comment on two additional areas. The bill calls for utilization management programs to be accountable to health care consumers and caregivers in ways that almost everyone on the committee could support, and that I believe responsible practitioners also support. Many consumers and caregivers are concerned that they are losing control over clinical decisions about health care, as business priorities compete with medical judgment in the current health care environment. Provisions in this legislation will improve the practice of case by case utilization management, although the issue of whether utilization reviewers should be certified in the same state where treatment is being provided is still unclear. Some of these provisions were included in amendments that I authored, and that the committee adopted.

I believe there is wide interest among health caregivers, utilization management programs, and consumers in moving beyond case by case utilization review to measures that will truly improve the quality of health care, assure that care is appropriate, and at the same time will control costs. On one level, these measures include moving to effective review of overall practice patterns by health care practitioners and their peers, and effective programs to improve practice where possible or protect the public from dangerous practitioners in rare cases. Some of the programs established in Title V of this bill begin to address this kind of approach.

We must also take a broader view of the health of our population, and giving specific authority to public bodies to monitor health status and to address the causes of poor health, be they physical, environmental, economic, or social. While I believe this bill takes steps to measure and address population-based illnesses, I regret that proposals I made to take more effective measures seemed unlikely to be adopted.

I also have to take exception to certain opinions expressed in these Committee Views on the role of the market in health care reform. While I recognize the importance of the market as an effective mechanism for distributing commodities ranging from toothpaste to televisions, and an engine for economic growth, I believe its usefulness in allocating social goods and services such as health care is currently highly overrated. Markets are about competition,

about winners and losers. They take no notice of equality, or fairness, or people's needs for high quality health care regardless of their income, where they live, or how healthy they are at birth. Traditionally, people have made conscious decisions about those issues, expressing the public will through publicly elected officials and publicly accountable institutions.

This legislation provides the opportunity for market forces to play a role in the health care system, a role ranging from influencing clinical decisions to controlling health care costs. This approach is balanced, as any market approach would have to be, by enforceable back up mechanisms for cost control.

In the coming decades, if we have the opportunity to look back on the results of this legislation, I would simply speculate that we will find that market concepts like making consumers accountable for their health care expenditures will sound much less like viable solutions for our health care problems, and that we will be examining truly effective measures that coordinate the best efforts of providers, consumers, and other payers to create a health care system that is both equitable and efficient.

I want to be clear that while I believe there is a distinction between the role of markets and the broader social role of public institutions, I do not propose that the government run or operate the health care delivery system.

The single payer system I have proposed would leave the health care delivery system in the same mix of private sector and public sector providers we have today. While state and federal governments would pay health care bills, the delivery system would retain its current mix of private and public caregivers. Single payer systems would leave caregivers and patients in control of clinical decisions. While there would be competition in the delivery system, it would be based on quality alone, without requiring consumers to choose their caregiver based on what they can afford to pay.

I believe the single payer system is the best option for several reasons. One is the expected and immediate cost reductions, due largely to the imposition of annual and global budgets, and to administrative savings. The Congressional Budget Office has estimated that a national single payer system would be likely to save at least \$110 billion a year in the fifth year of operation, compared to projected expenditures under the current system, and that savings would actually escalate after that time. It is estimated that individuals and the nation would spend far less under this system than they do currently—and everyone would be covered. Because of these cost savings, CBO has stated that a single payer system could reasonably offer to cover a comprehensive range of health benefits, including full coverage for prescription drugs, and community-based and institutional long term care.

Additionally, rural areas with dispersed populations and many inner city areas are generally underserved, and are unlikely to attract enough health care providers to create the competition that would bring market forces into play. In these areas, single payer may be the only viable alternative for covering the entire population at an affordable cost.

It is my view that a viably funded state single payer option, such as the one contained in this act, is a fundamental part of health care reform.

ADDITIONAL VIEWS OF SENATOR HARRIS WOFFORD

Health care reform should not be an abortion bill. Not an abortion control bill. Nor an abortion mandate bill. We should not use health care reform to upset either existing state laws governing abortion or our private health insurance system's coverage of abortion.

For me, the prime test of reform is that it should enable all Americans to have the kind of guaranteed health care benefits and choice of doctor and health plans that members of Congress and millions of federal employees now get. The way that the Federal Employees Health Benefits Program deals with abortion is instructive. Under that program, abortion coverage is not mandated. It's not prohibited. Plans can choose to include it or not, and consumers make their own choice of plan.

Under this approach to reform, some plans—by a religious hospital association, for example—could explicitly exclude abortions, or specify limited terms in which they would include abortion, such as rape or incest, or a threat to the life of the mother. Plans and providers cannot and should not be compelled to provide this procedure. At the same time, the choice of what plan to choose would be up to each individual.

As a practical reality, if the new system is seen to be mandating abortions in all plans, I do not think health care reform will pass. Some of the same religious and medical groups that most want to support universal health insurance would have to oppose it. And I understand why.

On the other hand, if the new system takes insurance coverage away from the great majority of women whose present private-sector health plans cover abortions as pregnancy-related services, there would also be no action—only more gridlock. The majority of American women, whatever limitations on abortion they do support, would not accept legislation that took that choice out of their existing private plans. I also understand why.

So I come back to the essential point: Health reform should not be an abortion bill. That is why I support amendments to make clear that reform legislation would not supersede or undermine state regulations on abortion permitted by the Supreme Court, such as Pennsylvania's. That is also why I will oppose amendments that seek to exclude coverage of abortion. I think that strikes the right balance.

The Chairman's Mark is wisely silent on the point of explicit inclusion of abortion. I think that would be a wise course for the Congress to take, one that will allow plans to choose to cover abortion or not, one that will provide real choice to consumers.

ADDITIONAL VIEWS OF SENATORS DAN COATS, JUDD GREGG, STROM THURMOND, AND ORRIN HATCH

The Health Security Act as passed by the Senate Committee on Labor and Human Resources represents the largest Government social experiment ever undertaken in the history of this country.

The committee bill would extend the reach of Government into the lives of every American, determine their health care needs, control their health care costs, make their health care choices. We are assured that a health care utopia is just one law away.

While the details of the health care debate are important, we should start our discussion at the beginning.

We question the assumption that Government knows best. We question it on the basis of decades of incredibly costly experience. We question it because there have been millions of casualties to our compassion.

Every Member of the Committee agrees that we as a Nation cannot deny Americans access to Health Insurance, nor impose the worry that health insurance will be lost with an illness or job change. The choice before the Committee was not between reform or no reform, but what type of reform. Unfortunately, the Committee Bill chose a Government-run system rather than a market-driven approach.

In a mere 8 days, the Committee approved the largest social program in United States history—one that will control $\frac{1}{4}$ of the United States economy, have profound effects on the lives of all Americans, and drastically change the way, Americans receive their health care.

Our problems with the Committee Bill are too numerous to detail in this space, so we will focus on ten key areas of concern:

1. Government control
2. Standard benefits package
3. Cost and regulatory impact
4. Taxes/spending cuts
5. Employer mandate—a new payroll tax
6. Premium caps
7. Rationing
8. Consumer choice/quality of care
9. Abortion
10. Privacy

GOVERNMENT CONTROL

When President Clinton first introduced his health care plan, he listed "simplification" as one of the six goals his bill would address. Despite this goal, it is clear that the Clinton Bill and the Committee Bill both create nightmarish bureaucracies.

Both bills are based on the assumption that Government is more efficient than the private sector. Yet, anyone who has dealt with

any Government Agency knows this assumption is false. One need only spend a short time at the Department of Motor Vehicles or the Post Office to understand the absurdity of this assumption.

We were promised simplification, yet the Committee Bill creates a national health care bureaucracy supported by more than twenty New Federal Agencies and Commissions [see appendix 1], including the Federal Health Plan Review Board, the National Practitioner, Data Bank, a long term care advisory committee, and long term care screening councils.

And the list goes on—but the granddaddy of all boards the bill creates is the National Health Board.

The National Health Board, which has been dubbed the “United States Supreme Court of Health”, is an all-knowing, all-powerful, 9-member board—whose collective wisdom is supposed to replace that of every American.

The National Board is granted hundreds of powers and functions [see appendix 2]. For example, the National Board will determine what is medically necessary with respect to the comprehensive benefits package. Instead of being a decision made between a patient and doctor, the National Health Board will now determine what services and tests are deemed medically necessary.

The National Health Board will have the authority to terminate a non-complying state system. In this event, The National Health Board would direct the Secretary of the Health and Human Services (HHS) to take over a State health care system and impose a 15 percent surcharge on insurance premiums.

The National Health Board will establish by regulation additional classifications of “permanent resident aliens” and “prisoners”. This would give the National Board the authority to define population classifications currently under the jurisdiction of the Attorney General.

The National Health Board would establish such rules as may be necessary to carry out the act. In other words, The National Board has carte blanche authority to govern $\frac{1}{7}$ of the United States economy and to create any new rules it deems necessary to carry out the act. Further, these rules will become final without any opportunity for public comment.

These are just a few examples from the hundreds of authorities granted to the National Health Board under the committee bill. The American people want us to improve our current health care system. They do not want us to supplant it with a government-run system.

STANDARD BENEFITS PACKAGE

The National Board will also have broad authority in determining what benefits Americans will receive. Congress and the National Board will determine a one-size-fits-all package of benefits. All Americans will receive the same benefits—regardless of their individual health care needs.

Despite the already generous benefits package outlined in the Committee Bill, experience shows that future Congresses will expand it. Congress has a rich history of saying “yes” to people; Congress is not very good saying “no”.

Over the past year-and-a-half, all Members of Congress have been visited by representatives of various health provider groups. Each of them makes a very compelling case that their benefit has to be included in the Government-mandated package.

Some of them have been successful. The Committee Bill expands the already generous package of benefits the President proposed. It adds expanded coverage for women, children, people with disabilities, and those with low-income, while substantially increasing benefits for WIC, mental health, and substance abuse.

Action taken by the House Education and Labor Committee is indicative of the benefit expansion process. In May, that committee approved an amendment to extend preventive and diagnostic dental coverage to adults on the date of enactment, rather than waiting until 2001, as the administration had proposed. This benefit alone is expected to add an additional \$7 billion annually to the cost of the benefits package.

Later that day, the same subcommittee adopted an amendment to add coverage of smoking cessation classes for pregnant women. All Americans—make, female, pregnant, or not—will pay for those classes.

Are these benefits worthwhile? Perhaps. But so are countless other benefits currently excluded from this bill. The American Consumer should be free to choose the benefits he or she wants. This should not be the role of the Federal Government.

COST AND REGULATORY IMPACT

The committee bill promises benefits without first understanding the costs involved. Prior to the mark-up, Chairman Kennedy said that his health reform bill would decrease the deficit by \$23 billion from 1995 to 2000—estimates he attributed to CBO, CRS, and OMB.

We wrote to the director of each of those agencies. On May 13, we received a letter from CBO Director Robert Reischauer indicating that CBO had not prepared estimates of the cost of the Kennedy Bill. On June 2, CRS Director Daniel Mulhollan sent a reply stating that neither CRS nor CBO “was able to fully model and develop premiums that reflect all features of the Kennedy proposal.” On June 8, we received a response from OMB Director Leon Panetta stating that OMB did not provide the labor committee with a cost analysis of the chairman’s mark.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, May 13, 1994.

Hon. DAN COATS,
*U.S. Senate,
Washington, DC.*

DEAR SENATOR: The Congressional Budget Office has received your letter requesting CBO’s estimate and analysis of the Chairman’s health reform mark released by the Committee on Labor and Human Resources on May 9. CBO does not have detailed specifications or draft legislative language for the proposal and has not prepared any cost estimate or analysis. Therefore, please understand

that we will be unable to answer your inquiry within the time you requested.

Sincerely,

ROBERT D. REISCHAUER, *Director.*

CONGRESSIONAL RESEARCH SERVICE,
LIBRARY OF CONGRESS,
Washington, DC, June 2, 1994.

Hon. DANIEL COATS,
U.S. Senate,
Washington, DC.

DEAR SENATOR COATS: I am writing to help clarify the nature of the estimates prepared by the Congressional Research Service [CRS] for the recent Labor and Human Resources Committee markup on health care reform. In discussions with staff at CRS, it is clear that we should be quite specific about what was prepared for the Committee.

Memoranda prepared on May 16th and 17th provide estimates of the effect on health insurance premiums if the proposed changes detailed in the memoranda were made to the Clinton health care reform proposal. The estimates assume that the population covered was the same as under the Clinton proposal. The estimated percentage change in premiums was the percentage change from estimates of Clinton proposal premiums. Given the time constraints facing the Committee, and the resources available at the Congressional Budget Office [CBO] or CRS, neither agency was able to fully model and develop premiums that reflect all features of Senator Kennedy's proposal. A full premium model of the Chairman's mark would need to account for a number of factors including: financing of subsidized populations, possible adverse selection issues, and interactions with other insurance programs such as the Federal Employees Health Benefits program. The compromise of providing estimated premium changes from the Clinton proposal was the best available approach given the limited resources of both CBO and CRS.

I hope that letter responds to your questions about our analysis.

Respectfully,

DANIEL P. MULHOLLAN, *Director.*

EXECUTIVE OFFICE OF THE PRESIDENT,
OFFICE OF MANAGEMENT AND BUDGET,
Washington, DC, June 8, 1994.

Hon. DANIEL COATS,
U.S. Senate,
Washington, DC.

DEAR SENATOR COATS: Thank you for your letter dated June 7, 1994, in which you asked about the Office of Management and Budget's [OMB] involvement in providing the Senate Committee on Labor and Human Resources with cost estimates of Chairman Kennedy's mark on health care reform. Over the past few weeks, OMB has provided technical assistance to the Committee staff and has estimated certain aspects of the Chairman's proposal. We did not

provide the staff with a full cost analysis of all the features of the proposal.

We commend the Committee on the progress it has made in developing a health care reform bill that achieves universal coverage and look forward to working with you in the coming weeks.

Sincerely,

LEON E. PANETTA, *Director*.

What do these letters mean? They mean that the majority of the committee voted for a bill with extraordinary financial implications without knowing the costs of such action. They mean the committee is promising people benefits without knowing the cost of those benefits—benefits which can only be paid for with either new taxes, severe cuts in Medicare and Medicaid that we don't think the Congress is prepared to make, severe rationing and price controls, deficit financing, or combinations of the above.

The majority apparently regards the bill's cost as a mere technical detail to be worried about a some time in the future. Senator Coats' amendment to require the committee to obtain official CBO estimates prior to reporting the measure to the Senate was defeated on a party-line vote. We were repeatedly assured that the committee staff had received enough "technical assistance" to know that the committee bill will not result in further increases in the deficit.

Yet, the directors of the three agencies on which Congress relies for cost estimates do not support this view. They recognize that, although the committee bill contains a package of benefits designed to have an actuarial value roughly equal to the benefits package proposed by the administration, actuarial values are not the same as premiums.

This difference is best illustrated by the CBO analysis of the Managed Competition Act. In preparing its cost estimates of this bill, CBO assumed that the standard benefits package would be identical in actuarial value to the Administration's standard benefits package. Yet, CBO concluded that the premiums for a family with children would be 22 percent higher under the Managed Competition Act and 19 percent higher for single couples and married couples without children. There are many reasons for this difference, involving how risks are pooled and how subsidies are structured.

The committee bill, while it starts with a package similar to the administration's, also makes fairly substantial changes in how risks are pooled and how subsidies are structured. The Administration, for example, would require all firms with fewer than 5,000 employees to participate in the community-rated pool. The committee bill initially excluded firms with more than 1,000 workers from joining the pool. This means that the costs of subsidizing people with higher risks would be spread across fewer firms, resulting in possible premium increases.

The committee adopted an amendment which would allow firms with between 500 and 999 workers to choose between joining the community-rated pool or being experience-rated. One can assume that these firms will choose the cheaper option, meaning that high

risk people will be more likely to be added to the community-rated pool, while low-risk people will be more likely to be experience rated. This, too, would potentially drive up premium costs. Finally, the bill provides more generous subsidies to firms with fewer than 15 workers. The costs of these higher subsidies will inevitably be passed on to larger firms, almost certainly in the form of higher premiums.

These and other features of the bill make it impossible, absent thorough analysis by CBO and other agencies, to calculate the premium costs. Since the costs of this bill are directly related to the premiums that will be charged for the Government-designed benefits package, the committee had no knowledge of the cost of the bill it voted to send to the full Senate.

Even if we had waited for official cost estimates, which this committee chose not to do, there would be ample reason to fear that we were creating new entitlement programs whose costs would spiral out of control.

A perfect example of this is the Medicare Program. When Medicare was enacted in 1965, it was projected that in 1990, Medicare would be spending \$9 billion a year. The actual expenditure in 1990 was \$67 billion—7½ times the estimate.

In 1936, the Social Security Board categorically stated that "Twelve years from now, you and your employer will each pay 3 cents on each dollar you earn, up to \$3,000 a year. That is the most you will ever pay." Social Security was originally financed by a 2 percent payroll tax. Today, the payroll tax is 15.3 percent.

In light of the Social Security precedent, we are gravely concerned that the committee bill proposes 17 new taxes and tax increases to finance his health care bill. These new taxes add up to a lot more than 2 percent of payroll.

The committee has also failed to provide an adequate regulatory analysis of the bill. Rule XXVI 11.(a) of the standing rules of the Senate not only requires an estimate of costs, but also requires an evaluation of the regulatory impact of a bill to be included in the committee report. The size of the committee's inter-related Federal/State Government structure will exceed any existing Federal domestic program. While estimates do not exist for the committee bill, the prototype Clinton Bill, according to the Federation of American Health Systems, has 818 new regulatory mandates and would require some 98,000 State and Federal workers to administer it. The Administration estimates a cost of \$11.5 billion in the first five years of the Clinton Bill in regulatory costs. By all estimates, the Kennedy Bill imposes an even greater regulatory burden.

One reason the United States has the world's best health care is our strong health care industry. The committee bill would impose so great a regulatory burden that United States industry would likely migrate to other countries or simply turn their efforts to non-health investments. The regulatory impact of the committee bill must be examined before enactment of this legislation.

TAXES/SPENDING CUTS

Just as the committee chose not to determine how much this bill will cost, it dodged the question of how to pay for it. The committee

bill contains a "sense of the committee" resolution that 17 tax increases [see appendix 3] should be enacted, including a tax on employers of up to 12 percent of payroll, tax on employees of up to 3.9 percent of payroll, a 2 percent payroll tax on small employers who do not participate in the program, a 2.5 percent administrative expense allowance on premiums, a one percent surtax on all health premiums, and a \$1.50 per pack increase in the cigarette tax. The Labor and Human Resources Committee has no jurisdiction over taxes, and thus, any such recommendations are meaningless. The committee is left, then, with a massive new spending program which is not paid for.

Furthermore, these taxes are certain to decrease wages, eliminate jobs and strangle research and development. Even so, they won't fully pay for the promised benefits. So the bill as reported contains a section expressing the "sense of the committee" that existing Federal entitlement programs—over which this committee has no jurisdiction—should be slashed in accordance with the administration's proposal. According to CBO, the administration's proposal would cut Medicare spending by \$218 billion over the next decade, and Medicaid spending by more than twice that amount (\$446 billion) over the same period. Cuts of this magnitude are certain to have a severely negative effect on the viability of these programs.

Of course, the committee did not vote to make these cuts, even though they are essential to financing the promises the committee bill makes. Instead, the committee expressed a "sense of the committee" that these cuts should be made, and thus ducked the issue. Congress is renowned for over-promising benefits and underfunding programs. The Committee bill stands firmly in this tradition.

EMPLOYER MANDATE—A NEW PAYROLL TAX

The committee bill mandates that employers pay for their employees' health care costs. While mandates are burdensome to employers, their cost ultimately is borne by workers in the form of lost wages, lost benefits and lost jobs. CBO made this point in its March 1994 report entitled, "The tax treatment of employment-based health insurance." That report states:

An often overlooked point is that the employer share of the cost of 'employer-provided' health insurance is ultimately passed on to workers in the form of lower wages and reductions in fringe benefits other than health insurance.

Why must employers pass on their share of health insurance premiums to workers? The answer is that, in a competitive industry, employers must pass on those costs in order to stay in business.

Over the long run, employers have to pay workers what they are worth—at least on average—if they want to stay in business.

As a result, if an employer 'provides' health insurance, it has to reduce wages (or slow the rate of growth of

wages) until the cost of compensation again matches the value of what the employee produces.

"The employee—not the employer—pays for health insurance." [CBO, "the tax treatment of employment-based health insurance," March 1994, pp. 1,2. emphasis added.]

The committee bill relies on the myth that employers are giving health insurance to their workers. In reality, as the CBO notes, employees pick up the tab.

In effect, the committee bill levies a new payroll tax on workers, a tax that, for many workers, is greater than the social security payroll tax. For workers in firms with between 75 and 499 employees and for workers in smaller firms with average annual wages in excess of \$24,000, the payroll tax can be as much as 15.9 percent (12 percent from the employer, 3.9 percent from the employee), compared with a social security payroll tax of as much as 15.3 percent (7.65 percent from the employer and employee).

As with the social security tax, the payroll tax imposed by the committee bill will hit lower and middle income people hardest. Those with the lowest wages are most at risk of losing their jobs.

It also would crease inequities between workers in firms of different sizes. Consider a family with an annual income of \$32,000, whose principal wage-earner is employed in a firm with 100 workers. According to CBO, their mandated insurance coverage under the administration bill would cost an average of \$5,565 in 1994. Assuming that this premium would be the same under the committee bill and assuming that it would increase only at the rate of CPI, their coverage would cost \$6,270 in 1998, the first year in which the bill is fully implemented.

The "employer" contribution to their coverage would be capped at the lesser of 80 percent of \$6,270 or 12 percent of their wages. In this case, the "employer" share would be 12 percent of wages or \$3,840. Similarly, the employee share would equal 3.9 percent of wages of \$1,248. The total payroll tax on this family would amount to 15.9 percent of their wages, or \$5,088.

But if the principal wage-earner were employed in a firm with 25 workers and the average salary in that firm was \$21,000, their payroll tax would be considerably less—\$4,256, an amount that is \$836 less than the tax paid by a worker in a larger firm.

If the principal wage-earner were employed in a firm with 15 workers, the payroll tax would be still less—\$3,840, or about \$100 per month less than the tax paid by a worker in a firm with 100 workers.

It is important to note that all of these families, regardless of what portion of their income they pay in new taxes imposed by this bill, get the same benefits. Those who pay more will receive no better coverage than those who pay less. Some, in fact, are receiving similar benefits already, but would still have to pay more to maintain those benefits under the committee bill.

Similar inequities would occur between two-earner families and households with one wage-earner. Consider a two-earner couple with a combined income of \$60,000. Both workers would have to pay the 12 percent "employer" share of the payroll tax. The combined tax, adding the "employer" share (\$7,200) to the "employee"

share (\$1,254, which represents 20 percent of the family premium), would be \$8,454.

But a single-earner family with \$120,000 in income would pay \$6,270 for the same coverage—nearly \$2,200 less than the two-earner couple who earned half as much.

The committee report disguises these inequities with rhetoric about “shared responsibility” between employers and employees. In reality, as CBO has noted, workers will pay for these benefits in foregone wages. And regardless of what they pay, they will receive the same level of coverage. Its time that the committee level with the American people—mandates in this bill will impose a new tax on working people.

Much has been written about job loss and wage loss resulting from mandates. Estimates for job loss range from a low of 600,000 (Rand Corporation) to a high of 3.8 million (Consad Research Corporation) with an average probable loss of 1.0 million jobs. A compilation of 41 sources documenting this serious job loss is included at the end of these additional views. [see appendix 4]

PREMIUM CAPS

The majority also misrepresents the effect of the bill’s global budgeting through “premium caps.” These caps will squeeze needed resources out of the health care system and lead to rationing of medical care.

In establishing the baseline for those caps, the committee bill uses sleight of hand to hold costs to an artificially low level. In commenting on a similar provision in the Clinton bill, the chief actuary for HHS Health Care Financing Administration [HCFA] was reported in the November 1993 edition of *The Actuary* as saying, “The actuarially determined premiums for the first year of reform, 1996, are reduced by nearly twenty-five percent by the global budget.” How does the committee bill cut health spending by twenty-five percent in 1996? They do this by excluding the costs of providing medical care to AFDC and SSI recipients from the baseline, and by understanding the costs of providing medical care to other Medicaid recipients.

The incorrect arithmetic formula resulting in underfunding health care by twenty-five percent in its first year. Moreover, in the out years, growth is rapidly cut to zero. Thus, by its inherent design, the committee has created a health care system only able initially to spend 75 cents for each current dollar of services in its first year, and in its out years, the real value of that 75 cents will shrink by five percent per year.

Each member of this committee is concerned about the need to control health care costs. But premium caps are an arbitrary attempt to hold back prices which do not address the real cause of the problem.

Let’s look at what some of the ill effects of premium caps would be.

Most health care cost increases are due to the increased use of services, especially more sophisticated services. Our sophisticated health care delivery system—particularly innovative research and manufacturing, such as medical technology—is second to none in the world.

If you agree as a premise that cost increases are due to the volume and complexity of services, then it must follow that premium caps could not be implemented without a measurable effect on the number or type of health care services that Americans receive.

The Chairman's bill would enhance the already accelerating development of the managed care market. Obviously, that would require a concomitant infusion of new capital for two principal reasons: (1) to organize the new networks of providers and build the information infrastructure to support those networks; and (2) to guarantee solvency in the case of unexpected losses.

How are insurers to attract these investment funds or generate the capital internally if they must operate under the dark cloud of the premium cap? The health insurance association of America estimated that the Clinton bill would require \$30 billion to \$90 billion of new capital. The only way to generate this capital to serve the expanded delivery system is through a reasonable rate of return for insurers. Over the last decade, the profit margin for the insurance industry as a whole was not even 2 percent of premiums.

If the committee imposes a ceiling on premiums, insurers simply will not be able to expand to compete in the new marketplace. And if this action drives the insurers out of business, who is left? The Government. The Government would become the insurer, and we will have enacted a single payor system.

Finally, we simply don't think premium caps would be workable from an administrative standpoint. There is a substantial question about whether we have the data which would allow the national health board to develop specific premium targets for each region in the country. According to the congressional research service (CRS), "the data requirements for making such [per capita premium] calculations are extensive and go beyond what is currently available today."

When the medicare prospective payment system (PPS) was enacted in 1983, the administration had detailed cost reports from each hospital for years. Even though the information was available, when HCFA set the payment limits for each procedure (the "DRGs" or diagnosis-related groups) there was a great outcry from not only the providers, but from the regions, as well. It became obvious that there were inequities. For example, urban teaching hospitals were getting too much, and rural hospitals weren't getting enough. It has taken years to correct those problems.

This experience leads us to conclude that even if premium caps were a good idea—which they are not—they could not be implemented. We do not have the detailed regional data necessary to implement this new system.

RATIONING

"Rationing" is a word that is not looked upon kindly by the American Public, but is the inevitable result of the premium caps in the committee bill. Every State-determined health service area will have an annual budget established in Washington that is kept by putting caps on insurance premiums. Those premiums eventually set the price of everything else in the system—from tongue-depressors to brain surgery.

When prices are kept artificially low to meet a federally-mandated budget, demand for health services chases a dwindling supply. The results are shortages—and those shortages result in rationing of care.

The rationing that results from government price controls creates a health system that works well for everyone—except the sick.

The ostensible reason for including premium caps in the committee bill is to achieve universal coverage. We think market solutions providing access to health insurance and subsidies will provide adequate coverage without imposing massive government intrusion and rationing of medical care. While universal insurance coverage is a desirable goal, experience has shown the goal to be illusive.

Under Social Security only about 94 percent of civilian workers are covered. Hawaii with its universal coverage has only about 94 percent of its population insured, despite two decades under an employer mandate. Yet, Lewin-VHI has estimated that with only insurance reform, 100 percent tax-deductibility for individuals and the self-employed, and low-income premium subsidies up to 200 percent of poverty, the United States could achieve 91 percent insurance coverage which would cover 97 percent of all health care costs.

QUALITY OF CARE/CONSUMER CHOICE

The bottom line is that the committee bill would radically change the way Americans receive their health care.

Under the committee bill, 220 million Americans would be forced to give up their current insurance plans. The only plan available to them would be the one designed by Congress and implemented through vast new bureaucracies. The committee bill would outlaw existing employer-sponsored plans. Employers—whether they self-insure or obtain coverage from insurance carriers—would be required to offer the government-prescribed uniform benefit package, whether or not that plan makes sense for them or their employees.

The bill would make it illegal for families to choose their health care benefits. Congress and a new Federal bureaucracy would make that choice for them. Americans should not be forced to give up their right to choose the particular benefits they need in health insurance. That choice should be made by families, not bureaucrats.

Under the committee bill, an individual's choice of doctor would be severely limited. More than likely, they would be forced into an HMO.

Under the committee bill, Federal bureaucrats and numerous others would have broad access to private medical records.

Under the committee bill, Federal bureaucrats would determine how many specialists there would be and in what field doctors would practice.

Under the committee bill, Congress and the National Health Board would decide which benefits Americans can receive, which tests are appropriate, and which treatments are medically necessary.

Under the committee bill, Federal bureaucrats would decide whether expensive technology should be used on the elderly, pre-

mature babies, or the chronically ill. Are Government Agencies really prepared to draw these ethical lines?

Our current health care system, for all its flaws, allows these decisions to be made by the market and consumers. The field of medicine is always changing. New tests supersede old ones. New treatments render old ones obsolete. And the market responds to these innovations.

Under this bill, innovation would respond to Congress and the National Board. Before a new test would become readily available to patients, a huge health care bureaucracy would have to meet to hammer out new rules and regulations. Advisory boards would convene, congressional committees would hold hearings, and Federal Departments and Agencies would undertake studies.

Meanwhile, a patient sits, waiting for the bureaucracy to approve a treatment on which that patient's life depends.

Health reform will work only if it spurs innovation. Such innovation not only saves lives, but it can actually reduce health care spending. Our market-based system has helped produce thousands of innovations that improve health care quality while curbing health care costs.

For example, a new drug called capoten is now being used to treat patients with diabetic nephropathy. The use of the drug could reduce health care spending by \$2.4 billion over ten years by keeping these patients from needing dialysis.

A sophisticated device known as a pet scanner can cost several million dollars. But it provides physicians with information that can sometimes prevent open-heart surgery (at a cost of roughly \$30,000 per operation), and it can prevent painful tests for epilepsy that can cost more than \$20,000 per test.

The average cost of coronary artery surgery is \$41,000. While the annual cost to treat coronary artery disease with drug therapy is only \$1,000.

Surgery for ulcer conditions can cost \$25,000, compared to \$1,000 to treat that same condition with medication.

Markets spur innovation; bureaucracy strangles it in a web of red tape. The committee bill puts medical innovation—and the quality of care that Americans have enjoyed for so long—at the mercy of bureaucracy. The committee bill would lock outdated technologies into place and inhibit innovation.

ABORTION

We are also deeply troubled by the inclusion of elective abortion in the basic benefits package in the committee's bill. Congress has never before considered legislation that would so dramatically expand the practice of abortion in America as would this proposal.

If passed, this proposal would have four devastating results. First, it would prohibit health insurance plans from either not including abortion or limiting their coverage of abortion services. Second, it would require virtually all wage-earners and employers, regardless of religious or moral objections, to subsidize the provision of abortion through mandated premiums. Third, it would nullify nearly 20 years of legislative history limiting tax funding of abortion on demand for low-income populations. And fourth, it would nullify constitutionally permissible state regulation of abortion

such as parental consent laws, waiting periods, and limits on late term/post viability abortions.

During committee consideration of the benefits package, Senator Coats offered an amendment which would have allowed legitimate medically necessary abortions to be included in the package. Under the Coats Amendment, abortions necessary to save the life of the mother or in the event of rape or incest, would have been allowable subsidized benefits in the package. Under the Coats Amendment, elective abortions would not be required to be subsidized by taxpayers and employers as they would in the committee proposal.

The Coats Amendment would have protected working Americans and their employers from being compelled by force of Federal law to purchase abortion insurance and pay for abortion on demand, while at the same time allowing those individuals who want abortion insurance to purchase that coverage at their own cost.

Though the Coats Amendment was rejected by this committee, clearly, it would have been supported by an overwhelming majority of the American people. In a May 1994 poll released by the Journal of the American Medical Association (JAMA), only 30 percent of those surveyed wanted abortion included in the standard package even if no extra tax or premium were necessary. Only 14 percent thought the health package should include abortion if additional taxes/premiums were required.

Senator Gregg offered a companion amendment designed to preserve constitutionally-permissible regulation of abortion by a State or a subdivision of a State. The purpose of this amendment was to protect State laws regarding parental notification and consent, informed consent, post-viability abortions, and other State abortion restrictions. The committee rejected this amendment, again demonstrating the divergence of its views from those of the American people.

Clearly, the issue of abortion has divided and continues to divide our Nation. In the words of Michael Kinsley, "simple political comity suggests that this passionate minority should not have its noses rubbed in the dirt. Respect for the sensitivities of a minority, even this minority, ought to come easily to liberals and civil libertarians."

On the issue of abortion, the committee proposal is anything but sensitive. In fact, it is clear from the inclusion of elective abortion over legitimate medical services such as eye glasses and hearing aids for the elderly (which the bill excludes) that political concerns far outweighed concern for medical care and treatment. This is unfortunate, and one of the fatal flaws in this legislation.

PRIVACY

Most Americans believe that certain fundamental protections flow from living in a constitutional democracy. For example, most Americans probably expect their visits to a doctor to be between themselves and the doctor, and not a matter for public consumption. However, the committee bill authorizes unprecedented invasion into those traditionally protected areas.

Title V of the committee bill includes broad provisions for the establishment of a national data bank of health information which

will include, among other information, private patient medical records.

Until now, private medical information has generally been protected by doctor-patient privilege—a privilege that belongs solely to the patient, and requires that no information about the patient be shared without his/her valid consent. That privilege would have been severely limited by the original committee bill.

However, during committee consideration of Title V, Senator Coats offered, and the committee accepted, an amendment aimed at strengthening this privilege by insuring that no identifiable patient information would be released without the valid written consent of the person about whom the information is maintained. The amendment required a separate written consent for each proposed disclosure, and explicitly prohibited consent from being given on a form used to authorize or facilitate the provision of, or payment for, health care.

Although that amendment was changed considerably by a later amendment, its primary purposes remain in the final bill. However, notwithstanding its inclusion, we continue to be concerned about the scope of information proposed to be maintained in the National Data Bank, and the purpose for which that information would be maintained.

Specifically, we are concerned about the potential abuse of such a massive medical info-highway. Already, enormous amounts of private information can be accessed with very little effort. During committee debate on this issue, we mentioned several noteworthy examples of real-life medical information leaks, and how devastating they can be.

A national data base will only complicate and increase the potential for such abuse. Without confidence that private information will remain just that, private, we are concerned that many will be discouraged from seeking the medical attention they need. In a recent public opinion poll conducted by Louis Harris, 85 percent of those surveyed indicated that protecting the confidentiality of medical records is extremely important in National Health Care Reform.

We should not, at this time, move forward with such an enormously unclear and potentially harmful initiative without having the benefit of extensive Congressional hearings—including an opportunity to hear from both doctors and patients. Much more needs to be understood before we establish a national health data network.

CONCLUSION

American health care is the world's envy. This bill jeopardizes that high level of care. The current system can be improved, but we have no faith it can be replaced by the abstract plans of a government that has proven its incompetence in social engineering. People—real individuals—suffer from the Federal Government's good intentions. Humility, learned from three decades of failed social experimentation, is a demand of our recent history. And this is where our debate should begin.

We cannot endorse a proposal that adds layers of bureaucratic, Government rules and regulations, more taxes on American fami-

lies and businesses, and particularly, legislation that adds many new Federal entitlements without first the understanding of the costs of such action.

The American people will intuitively recognize the committee bill for what it is: too big, too bureaucratic, too inflexible, too expensive, and too taxing.

The committee bill is ambitious, but deeply flawed. It tries to swim against the tide of market forces, but the market is never cheated for long. Instead of price controls, rationing, and taxes, we need to examine reforms that use markets, not distort them. That would be a healthier approach, in every sense of the word.

ALAN COATS.

JUDD GREGG.

STROM THURMOND.

ORRIN HATCH.

(Appendix 1)

NEW FEDERAL BUREAUCRACY

NATIONAL CENTER FOR CONSUMER ADVOCACY [Sec. 1207]

NATIONAL HEALTH BOARD [Sec. 1601]

ADVISORY COMMITTEE ON MEDICAL TECHNOLOGY STUDY [Sec. 1672]

FEDERAL ADVISORY GROUP ON HOME AND COMMUNITY-BASED SERVICES
FOR PEOPLE WITH DISABILITIES [Sec. 2701(a)]

STATE ADVISORY GROUPS ON HOME AND COMMUNITY-BASED SERVICES
FOR PEOPLE WITH DISABILITIES [Sec. 2701(b)]

LONG TERM CARE SCREENING COUNCILS [Sec. 2747]

NATIONAL COUNCIL ON GRADUATE MEDICAL EDUCATION [Sec. 3001]

NATIONAL COUNCIL ON GRADUATE NURSE EDUCATION [Sec. 3072]

NATIONAL ADVISORY BOARD ON HEALTH CARE WORKFORCE
DEVELOPMENT [Sec. 3081]

HEALTHY STUDENTS - HEALTHY SCHOOLS INTERAGENCY TASK FORCE [Sec.
3603]

NATIONAL QUALITY COUNCIL [Sec. 5001]

NATIONAL HEALTH CARE DATA NETWORK [Sec. 5101]

FEDERAL HEALTH PLAN REVIEW BOARD [Sec. 5205]

ADVISORY COMMISSION ON REGIONAL VARIATIONS IN HEALTH
EXPENDITURES [Sec. 6006]

NATIONAL TRANSITIONAL HEALTH INSURANCE RISK POOL [Sec. 11007]

(Appendix 2)

**Powers and Functions of the National Health Board
under the Kennedy Plan
(bill section numbers in brackets)**

Powers and Functions Contained in Just Titles I, V and VI

1. Establish conditions for eligibility of Diplomats and Other Foreign Government Officials [1005]
2. Establish transition rules for states that comply with Act prior to general effective date of 1998 [1006]
3. Specify notice that qualifying employers must provide to states [1006]
4. Establish national rules respecting individuals who will be treated as children under the Act [1011]
5. Provide for such additional exceptions and special rules respecting individuals who will be treated as children [1011]
6. Specify coverage areas for large group sponsors with respect to full time students [1012]
7. Provide for special rules for spouses who live in different health care areas [1012]
8. Specify those health professional services that shall be treated as inpatient hospital services when provided to an inpatient of a hospital [1111]
9. Define high risk populations with respect to clinical preventive services [1114]
10. Modify/Specify the age-appropriate immunizations, tests or clinician visits respecting clinical preventive services [1114]
11. Establish requirements for immunizations, tests or clinician visits respecting clinical preventive services outside of the age range [1114]
12. Specify those health professional services that shall be treated as inpatient, residential, intensive nonresidential, and outpatient mental illness and substance abuse treatment [1115]
13. Identify authoritative texts specifying diagnostic criteria for mental disorders or substance abuse disorders to define diagnosable mental disorder and diagnosable substance abuse disorder [1115]
14. Perform all functions of the Secretary of Health and Human Services (HHS) as delegated to HHS under certain provisions of the Social Security Act [1117]
15. Establish a periodicity schedule for the vision care coverage with regard to eyeglasses and contact lenses that are covered for individuals less than 18 years of age [1125]
16. Specify the emergency dental treatment eligible for dental care coverage under the Act [1126]
17. Define diseases, disorders, or other health conditions that qualify as investigational treatments under the Act [1128]
18. Determine the Out-of-Network Coinsurance Percentage with respect to lower cost sharing [1132]
19. Provide for an exception to the Out-of-Network Coinsurance Percentage [1132]
20. Determine what is not medically necessary with respect to the comprehensive benefit package [1141]
21. Promulgate such regulations or establish such guidelines as may be necessary to assure uniformity in the application of the comprehensive benefit package across all health plans [1151]
22. In its discretion, by regulation expand the comprehensive benefit package prior to 2001 [1152]
23. Specify and define specific items and services as clinical preventive services for high risk populations and establish and update a periodicity schedule for such items and services [1153]
24. Update the periodicity schedules for the age-appropriate immunizations, tests, and clinician visits [1153]
25. Establish rules with respect to coverage for an immunization, test, or clinician visit that is not provided to an individual during the age range for such immunization, test, or clinician visit [1153]
26. Otherwise modify the items and services described as clinical preventive services [1153]
27. Promulgate such regulations as may be necessary to carry out section exclude certain services that are not medically necessary or appropriate [1154]
28. Specify the form and manner for the document a state must submit that describes the State health care system that the State is establishing in order to be approved as a participating State [1200]
29. Require states to submit annually such information as needed to determine that the system shall

* Reflects board functions contained in original Kennedy mark.

- meet the applicable requirements of this Act for the succeeding year [1200]
30. Require states to submit annually such information as needed to determine that the State operated the system during the previous year in accordance with the Board's approval of the system for such previous year [1200]
 31. Establish any additional standards with regard to the states' implementation of mandatory reinsurance systems [1203]
 32. Establish rules governing affiliations between entities offering supplemental insurance and plans [1203]
 33. Promulgate rules respecting guaranty fund payments for the operational, administrative, and other costs and debts of the plan [1204]
 34. Require the information to be included for states and plans to comply with the Act's consumer information provisions [1206]
 35. Establish rules as to the states' procedures through which small employers may make an election to be treated as a community-rated employer [1209]
 36. Approve the applications of states to operate single-payer systems [1221]
 37. Determine satisfaction of single payer state's mechanisms of cost containment [1222]
 38. Specify manner through which single payer states shall coordinate their enrollment activities [1223]
 39. Specify the reasonable restrictions on coverage permitted under a fee-for-service plan [1231]
 40. Promulgate rules regarding the responsibilities of states relating to individuals whose applicable health plan is not a community-rated plan (or an experience-rated plan) and other individuals the state is unable to identify as eligible individuals [1232]
 41. Establish rules with respect to the states' enrollment of new residents [1232]
 42. Promulgate rules respecting the annual open enrollment period to change plan enrollment that each participating State must hold [1232]
 43. Establish federal standards under which the states may define good cause for the states' procedures under which eligible individuals enrolled in a plan may disenroll from the plan for good cause [1232]
 44. Establish any rules under which the states shall select plans in which to enroll individuals in cases where community-rated individuals fail [1232]
 45. Specify manner in which states shall coordinate its activities, including enrollment and disenrollment activities, with other States [1232]
 46. Establish rules governing liability for payments to plans [1251]
 47. Prescribe manner in which collection entities must maintain information they obtain in the performance of their duties [1251]
 48. Specify fiduciary standards for contracting entities that will be responsible for the administration, management, and distribution of premium payments and other funds provided under the Act [1252]
 49. Specify procedures governing the transfer of premiums among plans to account for full-time students [1257]
 50. Determine appropriate amounts owed under the Act to a State or the appropriate contracting entity [1258]
 51. Establish rules relating to the area(s) in which the per capita amounts submitted by uniformed services health plans shall be treated as final bids [1261]
 52. Permit a state to designate an independent agency of the state as the consumer purchasing cooperative sponsor in one or more health care coverage areas [1301]
 53. Study the feasibility of a direct elections process for the selection of members of the board of directors of consumer purchasing cooperatives, and prepare recommendations on instituting such a process, by June 1, 1996 [1302]
 54. Promulgate standards of conduct for any administrator, officer, trustee, fiduciary, custodian, counsel, agent, or employee of any cooperative [1304]
 55. Promulgate regulations to govern the cooperatives' coordination of enrollment with the state-designated enrollment process [1317]
 56. Establish rules under which certain individuals shall not be treated as experience-rated individuals under large group plans [1401]
 57. Define seasonal or temporary workers who shall not be treated as experience-rated individuals

under large group plans [1401]

58. Accept notification by large group sponsor (other than a large employer) to terminate its large group sponsor status [1403]
59. Establish procedures under which individuals enrolled in a health plan may disenroll from the plan and enroll in another health plan [1502]
60. Provide rules under which one plan is liable to another for the costs of an individual who changes enrollment from the plan due to a pattern of underservice [1502]
61. Establish any alternative standards relating to the fiscal soundness of health care carriers [1509]
62. Develop standards for the stop-loss protection a physician incentive plan must provide if the health plan places a physician or physician group at financial risk for services not provided by the physician or physician group [1513]
63. Determine whether a health plan and any physician or physician group with whom the health plan contracts is in compliance with utilization management protocols of the Act [1513]
64. Develop minimum standards that prohibit certain marketing practices by entities offering supplemental health benefit policies [1522]
65. Establish standards for cost sharing policies so that the plan offers each such individual a choice of a policy that provides standard coverage and a policy that provides maximum coverage [1523]
66. Establish rules that determine the amount of FEHBP supplemental plans that takes into account any expected increase in utilization of the items and services in the comprehensive benefit package resulting from the purchase of the plan by individuals enrolled in a community-rated health plan [1523]
67. Specify the manner in which FEHBP supplemental plans provide additional payment to the community rated plan for individuals enrolled in the supplemental plan and in a community-rated plan [1523]
68. Interpret the comprehensive benefit package, adjust the delivery of preventive services, and take such steps as may be necessary to assure that the comprehensive benefit package is available on a uniform national basis to all eligible individuals [1603]
69. Recommend to the President and the Congress appropriate revisions to the comprehensive benefit package [1603]
70. Oversee the cost containment requirements of the Act, and certify compliance with such requirements [1603]
71. Develop and implement standards relating to the eligibility of individuals for coverage in applicable health plans and provide such additional exceptions and special rules relating to the treatment of family members as the Board finds appropriate [1603]
72. Establish and have ultimate responsibility for a performance-based system of quality management and improvement [1603]
73. Develop and implement standards to establish a national health information system to measure quality [1603]
74. Establish requirements for participating States [1603]
75. Monitor State compliance with the Board-established requirements [1603]
76. Provide technical assistance to states [1603]
77. Ensure access to the comprehensive benefit package for all eligible individuals [1603]
78. Establish premium class factors [1603]
79. Develop a methodology for the reinsurance and risk-adjustment of premium payments to community-rated health plans [1603]
80. Establish minimum capital requirements and requirements for guaranty funds [1603]
81. Establish standards for health plan grievance procedures that are used by enrollees in pursuing complaints [1603]
82. Specify those periods which shall include a national, uniform open enrollment period, in which eligible individuals may change the applicable health plan in which they enrolled [1603]
83. Prepare and send to the President and Congress an annual report addressing the overall implementation of the new health care system [1604]
84. Appoint such officers and employees as are necessary to carry out its functions [1605]
85. Contract with any person (including an agency of the Federal Government) for studies and analysis

- as required to execute its functions [1605]
- 86. Establish advisory committees [1605]
- 87. Secure directly from any department or agency of the United States information necessary to enable it to carry out its functions [1605]
- 88. Delegate any function to such officers and employees as the Board may designate [1605]
- 89. Authorize such successive redelegations of its functions as the Board deems to be necessary or appropriate [1605]
- 90. Establish such rules as may be necessary to carry out the Act [1605]
- 91. Approve State health care systems [1611]
- 92. Issue regulations by July 1, 1995, prescribing the requirements for State health care systems [1611]
- 93. Notify a State within 7 working days after the date of a state's submission, whether or not the state's document seeking approval is complete and provides the Board with sufficient information to approve or disapprove the document [1611]
- 94. Establish by regulation an additional period (not to exceed 45 days) in which to a state may submit additional information as the Board may require [1611]
- 95. Review a State's designation of health care coverage area boundaries to determine whether such boundaries comply with the non-discrimination requirements of the Act [1611]
- 96. Approve revisions to State health care systems [1611]
- 97. Determine if that a State's failure to establish a health care system that meets all the Act's requirements substantially jeopardizes the ability of eligible individuals in the State to obtain coverage for the comprehensive benefit package [1612]
- 98. Terminate a non-complying State system [1612]
- 99. Notify the Secretary if its substantially jeopardizes determination for a reduction in HHS payments to the State or for an HHS takeover of the state system [1612]
- 100. Approve a State's application for a health care system after a federal takeover, so HHS will terminate the federal system, and the State can operate its own system [1624]
- 101. Establish a premium class factor for each class of family enrollment that reflects the relative actuarial value of the comprehensive benefit package of the class of family enrollment compared to such value of such package for individual enrollment [1631]
- 102. Develop a risk adjustment and reinsurance methodology [1641]
- 103. Make such improvements in such methodology as may be appropriate to achieve the numerous purposes described in section 1641(b)(1) [1641]
- 104. Determine what non-statutory factors are material and should be taken into account in the development of the risk adjustment and reinsurance methodology [1641]
- 105. Determine whether certain factors are sufficient to adjust premiums to take into account the enrollment in plans of AFDC recipients and SSI recipients, so other statutory factors need not be used [1641]
- 106. In developing the risk adjustment and reinsurance methodology, give special consideration to the unique problems of adjusting payments to health plans with respect to individuals with mental illness [1641]
- 107. In developing the risk adjustment and reinsurance methodology, give special consideration to the special enrollment and funding provisions relating to veterans, military, and indian health plans [1641]
- 108. Reduce or eliminate a reinsurance system at such time as the Board determines that an adequate prospective payment adjustment for health status has been developed and is ready for implementation [1641]
- 109. In developing the methodology for a mandatory reinsurance system, provide for health plans to make payments to state-established reinsurance programs for the purpose of eliminating incentives for plans to discriminate against individuals on the basis of their expected utilization of health services [1641]
- 110. In developing the methodology for a mandatory reinsurance system, specify the manner of creation, structure, and operation of the system in each State, including the manner (which may be prospective or retrospective) in which health plans make payments to the system, and the type and level of reinsurance coverage provided by the system [1641]

111. Develop the mandatory reinsurance methodology developed in a manner consistent with the privacy standards promulgated by the Board [1641]
112. Undertake experimentation with alternative reinsurance and risk adjustments methods in one or more different States to determine the most appropriate method to be used on a national basis [1641]
113. Approve a state's adjustments to the national risk adjustment and reinsurance methodology that reflect State specific patterns of disease or population characteristics.
114. Establish standards under which States may provide adjustments in the Board's risk-adjustment methodology to provide a financial incentive for community-rated health plans to enroll individuals who are members of disadvantaged groups or populations vulnerable to discrimination due to their health status [1642]
115. Provide technical assistance to States in implementing the reinsurance and risk-adjustment methodology [1644]
116. Establish minimum capital requirements for carriers [1651]
117. Establish standards that provide for additional capital required to affect the financial stability of a carrier [1651]
118. Request the National Association of Insurance Commissioners to develop model standards for the additional capital requirements and to accept such standards as the standards to be applied or to modify the standards in any manner it finds appropriate [1651]
119. Establish standards for State guaranty funds [1652]
120. Establish rules for the extent to which the guaranty funds are liable for other claims of providers, contractors, employees, governments, or any other claimants [1652]
121. Specify a uniform, national annual open enrollment period [1660]
122. Provide when changes in enrollment during an annual open enrollment period shall take effect [1660]
123. Specify such other periods and occurrences for which an individual is authorized to change enrollment in health plans and when such change of enrollment becomes effective [1660]
124. Give permission to the Secretary of HHS to undertake (through contract or otherwise) collection activities (in relation to amounts owed to States, consumer purchasing cooperatives and large group sponsors, and for the benefit of such States, consumer purchasing cooperatives and large group sponsors) [1691]
125. Provide for the responsibilities of employers as to employees who live in a single-payer State [1701]
126. Specify employers' reporting requirements for information relating to employment of eligible individuals [1702]
127. Provide for the use of the regional centers (which are part of the electronic data network) to perform information clearinghouse functions with respect to employers, States, contracting entities, and consumer purchasing cooperatives [1702]
128. Specify other functions of the regional centers/information clearinghouses [1702]
129. Establish rules as to when an employee shall be considered to be employed on a full-time basis by an employer [1901]
130. Specify the method for computing hours of employment for employees [1901]
131. Establish rules for salaried employees for the conversion of the compensation to hours of employment [1901]
132. Establish by regulation additional classifications of permanent resident aliens [1902]
133. Issue regulations that provide for affiliated carriers to be treated as a single carrier where appropriate under the Act [1902]
134. Establish by regulation other classifications of nonimmigrants [1902]
135. Specify who shall be classified as "prisoners" under the Act [1902]
136. Provide exceptions to the rule that when only one spouse is a qualifying employee, the residence of the employee shall be the residence of the couple [1901]
137. Specify when the Act's reference to a "corporate alliance" is deemed to be a reference either to an "experience-rated employer" and when to a "large group sponsor" [1902]
138. Specify when the Act's reference to a "regional alliance" is deemed to be a reference to a contracting entity, to a State, or to a consumer purchasing cooperative [1902]

139. Specify when the Act's reference to a "health plan" is deemed to be a reference to a health plan or to a carrier [1902]
140. To issue all of its regulations on an interim basis that become final on the date of publication, subject to change based on subsequent public comment (as opposed to the standard prior notice-and-comment rulemaking procedure) [1911]
141. Establish a National Quality Council [5001]
142. Provide to the National Quality Council such staff, information, and other assistance as may be necessary to carry out the duties of the Council [5001]
143. Establish and maintain a priority list of performance measures that within a 5-year period it intends to consider for inclusion within the set of national performance measures (established by the National Quality Council) through an updating process [5003]
144. Upon recommendation of the National Quality Council, establish goals for performance by health plans and health care providers on a subset of the set of national measures of quality performance [5005]
145. Develop and implement a health information system [5101]
146. Establish privacy and security standards established for the national health information system [5101]
147. Specify the form and manner in which individuals and entities are required to collect or transmit health care information for or to the Board [5102]
148. Specify the frequency with which individuals and entities are required to transmit such information to the Board, including requirements for use of uniform paper forms containing standard data elements, definitions, and instructions for completion in cases where the collection or transmission of data in electronic form is not specified by the Board; requirements for use of uniform health data sets with common definitions to standardize the collection and transmission of data in electronic form; uniform presentation requirements for data in electronic form; and electronic data interchange requirements for the exchange of data among automated health information systems [5102]
149. As part of the health information system, oversee the establishment of an electronic data network consisting of regional centers that collect, compile, and transmit information [5103]
150. As part of the health information system, establish a system to provide for a unique identifier number for each eligible individual, employer, health plan, and health care provider [5104]
151. Ensure that a unique identifier number may not be used to connect individually identifiable health information that is collected as part of the health information system or that otherwise may be accessed through the number with individually identifiable information from any other source, except in cases where the National Health Board determines that such connection is necessary to carry out a duty imposed on any individual or entity under this Act [5104]
152. Establish by regulation the purposes for which a unique identifier number provided pursuant to this section may be used [5104]
153. Promulgate regulations for permissible uses of the health security card, including programs other than the health plans established by the Act for which the card can be used [5105]
154. Establish standards respecting the form of health security cards and the information to be encoded in electronic form on the cards [5105]
155. Determine any information beyond that specified in the Act that can be encoded on the health security cards [5105]
156. Take appropriate steps to register the card, the name of the card, and other indicia relating to the card as a trademark or service mark (as appropriate) under the Trademark Act of 1946 [5105]
157. Provide information and technical assistance to participating States, health plans, and health care providers with respect to the establishment and operation of automated health information systems [5106]
158. Sponsor research relating to the privacy and security of individually identifiable health care information; the development of consent forms governing disclosure of such information; and the development of technology to implement standards regarding such information [5121]
159. Establish education and awareness programs to foster adequate security practices by States, health plans, and health care providers; to train personnel of public and private entities who have access to individually identifiable health care information respecting the duties of such personnel with respect to such information; and to inform individuals and employers who purchase health care respecting

- their rights with respect to such information [5121]
160. Develop, promulgate, and publish in the Federal Register the following standard health care benefit forms: an enrollment and disenrollment form to be used to record enrollment and disenrollment in a health benefit plan; a clinical encounter record to be used by health benefit plans and health service providers; a claim form to be used in the submission of claims for benefits or payment under a health benefit plan [5130]
 161. Modify, update, or supersede any standard form or requirement developed, promulgated, or imposed under this section [relating to standard forms] through the establishment of a standard under the national health information system [5130]
 162. Appoint the members of the National Privacy and Health Data Advisory Council, and designate the chair [5140]
 163. Provide to the National Privacy and Health Data Advisory Council such staff, information, and other assistance as may be necessary to carry out the duties of the Council [5140]
 164. Consult with the States in their establishment and maintenance of complaint review offices for each health care coverage area established by the States [5202]
 165. Consult with the Labor Department in its promulgation of regulations regarding the implementation of the health plans claim procedure [5202]
 166. Consult with the Labor Department in its establishment and appointment of a Federal Health Plan Review Board, as well as the prescribing of rules to govern its proceedings [5205]
 167. Consult with the Secretary of Labor in assessing a civil penalty for violations of the Act [5206]
 168. Consult with the Secretary of Labor in commencing a civil action in any court of competent jurisdiction to enforce a civil penalty duly assessed [5206]
 169. Consult with the States in their required establishment of early dispute resolution programs [5211]
 170. There shall be no administrative or judicial review of any determination by the National Health Board respecting any matter under subtitle A of title VI [the Board's cost containment activities] [5232]
 171. Develop by regulation alternative dispute resolution methods for the use by States in resolving medical malpractice claims [5302]
 172. Set the threshold amount above which the parties must use the alternative dispute resolution procedure [5302]
 173. Establish the premium class factor to be used in determining the weighted average premium [6000]
 174. Compute and publish, not later than March 1 of each year the health care coverage area inflation factor for each health care coverage area [6001]
 175. Determine the factor by which the health care area inflation factor shall be increased reflect the ratio of (i) the actuarial value of the increase in benefits provided in that year under the comprehensive benefit package to (ii) the actuarial value of the benefits that would have been in such package in the year without regard to the increase [6001]
 176. Submit to Congress in 1999 recommendations on what the general health care inflation factor should be for years beginning with 2001 [6001]
 177. If the Congress fails to enact a law specifying the general health care inflation factor for a year after 2000, compute such factor for the year involved [6001]
 178. Determine the annual change in the real GDP per capita to be used in the computation of the health care inflation factor [6001]
 179. Specify the annual percentage increase in the CPI to be used in the computation of the health care inflation factor [6001]
 180. Develop a method for adjusting the health care coverage area inflation factor for each health care coverage area to reflect material changes in the demographic characteristics of community rate eligible individuals residing in the coverage area (in comparison with such characteristics for the previous year) as a result of one or more large employers terminating an election [6001]
 181. Develop a method for adjusting the health care coverage area inflator factor for each health care coverage area in order to reflect material changes in the demographic characteristics (including at least age, gender, and socio-economic status) and health status of community rate eligible individuals residing in the coverage area in comparison with the average change in such characteristics for such individuals residing in the United States [6001]

182. Annually provide for an adjustment of health care coverage area inflation factors using the methods specified [6001]
183. Have a process for consulting with representatives of States before establishing the health care coverage area inflation factors for each year under this section [6001]
184. Determine a national per capita baseline premium target [6002]
185. Determine the national average per capita current coverage health expenditures to be used in determining the national per capita baseline premium target [6002]
186. Determine the estimated population in the United States of community rate eligible individuals for whom such expenditures were determined [6002]
187. Determine the amount of total payments made for items and services included in the comprehensive benefit package (determined without regard to cost sharing) in the United States in 1993, based on the comprehensive benefit package that will exist in 1996, and subject to specified increases and decreases [6002]
188. Determine the estimated percentage that reflects the proportion of premiums that are required for health plan administration, any cooperative fees, for State administration (including costs for administration of income-related premium discounts and cost sharing reductions) and for State premium taxes, and adjust the total payment amount accordingly [6002]
189. Estimate the average percentage of total amounts payable for items and services covered under the comprehensive benefit package that will be payments in the form of cost sharing under a higher cost sharing plan, and the percentage reduction in utilization estimated to result from the application of high cost sharing [6002]
190. Update the total payment amount for each of 1994 and 1995 by the appropriate update factor for the year [6002]
191. Determine a health care coverage area per capita premium target for each health care coverage area, for 1996 and each subsequent year [6003]
192. Establish an adjustment factor for each health care coverage area with respect to the premium targets, considering the difference between the national average of the factors taken into account in determining the national per capita baseline premium target and such factors for the health care coverage area, including variations in health care expenditures and in rates of uninsurance and underinsurance in the different areas and including variations in the proportion of expenditures for services provided by academic health centers in the different areas [6003]
193. Have a process for consulting with representatives of States and purchasing cooperative before establishing the adjustment for health care coverage areas [6003]
194. Provide a method for computing a health care coverage area per capita premium target for each health care coverage area affected by changes in area boundaries, in the case of a State that changes the boundaries of its health care coverage areas [6003]
195. Determine if the actual weighted average accepted bid for a health care coverage area for a year exceeds the health care coverage area per capita premium target for the year [6003]
196. If the premium target is so exceeded, reduce the health care coverage area per capita premium target shall be reduced, by 1/2 of the excess percentage for each of the 2 succeeding years [6003]
197. Provide States and cooperatives with such information and technical assistance as may assist such States and cooperatives in carrying out the Act's bid and negotiation requirements [6004]
198. Request of the States any information concerning an estimation of the enrollment likely in each such plan of community rate eligible individuals through cooperatives; and the enrollment likely in each such plan of community rate eligible individuals by enrollment mechanisms other than cooperatives, or for a succeeding year the actual distribution of enrollment of community rate eligible individuals in community-rated health plans through cooperatives, and the actual distribution of enrollment of community rate eligible individuals in community-rated health plans through enrollment mechanisms other than cooperatives, and limitations on capacity of community-rated health plans [6004]
199. Determine a weighted average accepted bid for each year for each health care coverage area [6004]
200. Provide States and cooperatives with such information and technical assistance as may assist such States and cooperatives in carrying out the bid and negotiation requirements of the Act [6004]
201. Establish rules respecting the treatment of enrollment in plans that are discontinued or are newly offered [6004]

202. Annually notify a State if the weighted average accepted bid is greater than the health care coverage area per capita premium target for such area, and of the weighted average discount rate for the health care coverage area [6004]
203. Notify the State and each noncomplying plan of any plan payment reduction computed for such a plan and the opportunity to voluntarily reduce the accepted bid under in order to avoid such a reduction [6004]
204. Establish an advisory commission on regional variations in health expenditures [6006]
205. Submit to Congress by October 1, 1996, detailed recommendations respecting the specific method to be used to reduce or eliminate variations in health care expenditures -- which shall apply unless Congress passes a joint resolution of disapproval [6006]
206. Submit to Congress by July 1, 1995, detailed recommendations respecting the specific method to be used to reduce the regional variation of State payment amounts -- which shall apply unless Congress passes a joint resolution of disapproval [6006]
207. Establish rules to modify the requirement that, in the case of a community rated health plan that is first offered in a health care coverage area, that the maximum complying bid shall be the health care coverage area per capita premium target for the year [6011]
208. Issue regulations respecting the requirement that each community-rated health plan in the health care coverage area, as part of its contract with any participating provider or group of participating providers), shall include a provision that provides that if the plan is a noncomplying plan for a year, payments to the provider shall be reduced by the applicable network reduction percentage, and shall not include any provision which the State determines otherwise varies the payments to such providers because of, or in relation to, a plan payment reduction [6012]
209. Establish rules to modify the above requirement [6012]
210. Provide for an appropriate increase of the applicable network reduction percentage to take into account any estimated increase in volume of services provided that may reasonably be anticipated as a consequence of applying a reduction in payment [6012]
211. Compute and apply such increase differently for different classes of providers or services or different types of health plans the Board may define [6012]
212. Develop a methodology for calculating an annual per capita expenditure equivalent for amounts paid for coverage for the comprehensive benefit package within a large group sponsor [6021].
213. Compute a Statewide per capita premium target for each year for single-payer States [6031]
214. Establish rules under which large group sponsors and collection entities shall divide the combined premium between families proportionally [6102]
215. Establish rules for the pro-ration of credits and other amounts in determining the premium amount [6102]
216. Establish rules regarding the liability of employers for families employed full-time and part-time [6111]
217. Establish rules respecting the treatment of change of enrollment status, for the appropriate conversion and allocation of the credit amounts in a manner that reflects the relative values of the base employment monthly premiums among the different classes of family enrollment [6112]
218. Develop rules for applying the provisions regarding payments by non-qualifying employees to families whose employment status with respect to small employers changes during the year [6113]
219. With respect to the computation of the base employment monthly premium, specify the manner in which States shall determine for each couple class of family enrollment an estimated total number of additional workers for the couple-only and dual parent classes [6122]
220. With respect to the computation of the base employment monthly premium, determine the manner in which the premiums and families under plans shall be determined [6122]
221. Specify the date by which the determinations respecting the computation of the base employment monthly premium shall be made before the end of a year [6122]
222. Establish rules relating to the computation of the average annual wages for employers [6123]
223. Specify the manner in which demographic risk shall be measured [6123]
224. Require employers to submit any such information as the Board may require to determine demographic risk [6123]
225. Prescribe rules for individuals who are both substantial owners and an employees of a closely held

businesses for appropriately reducing premiums, in order to prevent such individuals from avoiding payment of the full amount owed through fraudulent or secondary employment arrangements [6162]

Prepared by the Office of Senator Judd Gregg

New Taxes in the Labor Committee Bill
(partial listing; bill section numbers in brackets)

- * An employer "premium" of up to 12 percent of payroll [6121-25]
- * An employee "premium" of up to 3.9 percent of payroll [6104]
- * An individual/family "premium" to the extent not paid by employers [6101-02, 1002]
- * A "premium" of the same amount on the self-employed [6126]
- * A 2 percent payroll "assessment" on small employers of more than 6 but less than 11 employees, and a 1% payroll "assessment" on those with 5 or fewer employees, that exercise an election not to participate in the system [6120]
- * A 1 percent payroll "assessment" on employers with more than 1000 employees or employers of 500 to 999 employees who elect to be treated as large employers [1914]
- * A 1.5 percent administrative expense "allowance" on premiums to be used as follows:
 - (1) 1.48 percent for state administrative functions,
 - (2) .02 percent for the new Office of the Consumer Advocate
 [1213]
- * An 1 percent premium "assessment" for federal biomedical research programs [1917]
- * A \$1.50 per pack increase in the cigarette tax [1917]
- * Up to a 15 percent "addition" to the premium target for health plan administration, cooperative fees, state administration, etc. [6002]
- * An extra 20 percent "premium" on employers for their "qualified retired beneficiaries" [1705]
- * A provider licensing "fees" to fund state medical boards [1201]
- * Each cooperative shall charge members a uniform membership "fee" [1305]
- * A state "share of its savings" paid to health plans, equal to 25 percent of the net reduction in the projected expenditures of the state for health care and related

services due to the Act, as estimated by the National Health Board [9100]

- * An "assessment" of 2 percent of premiums, imposed by the HHS Secretary, on each community-rated health plan, so long as necessary to generate sufficient revenue to cover any outstanding claims against a failed plan [1622]
- * A 15 percent "premium increase," to be charged if the federal government takes over or operates a state system [1623]
- * Any other revenue increases included in S.1757, the Health Security Act (the Clinton plan), but not specifically identified in the Kennedy bill [1917]

Prepared by the Office of Senator Judd Gregg

MANDATE FOR DESTRUCTION

**A SURVEY OF JOB AND WAGE DESTRUCTION
THAT WILL RESULT FROM REQUIRING EMPLOYERS
TO PAY FOR WORKERS' HEALTH INSURANCE**

**Prepared for the Joint Economic Committee
House Republican Caucus**

by

Joint Economic Committee Republican Staff

at the request of

**Representative Jim Saxton (R-NJ)
Republican Member**

June 1994

MANDATE FOR DESTRUCTION

A SURVEY OF JOB AND WAGE DESTRUCTION THAT WILL RESULT FROM REQUIRING EMPLOYERS TO PAY FOR WORKERS' HEALTH INSURANCE

INTRODUCTION

This Survey reviews 41 sources, most of the studies and reports known to the Joint Economic Committee Republican (JEC/GOP) staff, that deal with the employment and wage effects of an employer health insurance mandate. For analytical purposes, most of the studies treat an employer mandate like an increase in the minimum wage or as a payroll tax increase.

The studies that offer the most direct empirical estimates of the costs of an employer mandate are summarized under "Top Ten Sources"; the "Useful Sources" section reviews studies and reports that offer analysis, theory, or insight but few numbers; and reports that do not deal directly with employer mandates are classified under "General Background Sources."

The Top Ten studies estimate probable job loss under an employer mandate similar to that contained in the Clinton health plan. Five of these studies (Sources 2, 3, 4, 7, and 8) restrict their analysis to the impact of an employer mandate alone. The five other studies (Sources 1, 5, 6, 9 and 10) consider the effect of the Clinton plan in its entirety.

Estimated job losses range from a low of 600,000 (RAND Corp. [5]) to a high of 3.8 million (CONSAD Research Corp. [6]), with an average probable loss of 1.0 million jobs. If, for example, each restaurant in the country reduced employment by just one worker, 300,000 jobs would be lost. Table 1 summarizes the major findings on the impact of an employer mandate on jobs.

**Table 1 — Estimated Employment Effects of
An Employer Health Care Mandate**

Study Author/Organization	Probable Job Loss	Potential Job Loss
Office of Planning & Research/State of California [Source 1]	2.6 million	3.7 million
DRI/McGraw-Hill/CSE [2]	659,000	908,000
O'Neill & O'Neill/EPI [3, 7, 8]	780,000 - 890,000	2.3 million
GOP Staff/JEC [4]	710,000	807,000 - 1.2 million
Klerman & Goldman/RAND [5]	600,000	-
CONSAD Research Corp./NFIB [6]	850,000	3.8 million
Fiscal Associates/NCPA [9]	677,000	783,000
Vedder & Gallaway/ALEC [10]	1.0 million	-
AVERAGE	1.0 million	2.1 million

The range of the job loss estimates in Table 1 reflects the uncertain manner in which an employer mandate will affect employers and workers: An employer health insurance mandate will raise labor costs to employers but they will backshift as much as possible of their increased labor costs onto workers in the form of lower wages. The less employers are able to shift their increased labor costs back onto employees, the more jobs will be destroyed. The corollary finding is that the only way employers can refrain from reducing employment in the face of an employer mandate is to offset the increase in their labor costs by reducing wages. **Thus, employers and workers face a nasty tradeoff: Job Destruction or Wage Reduction.**

The RAND study [5], which finds the smallest employment effect of an employer mandate, assumes that 85 percent of the increased labor cost resulting from the mandate is successfully shifted back onto workers in the form of reduced wages. CONSAD [6] estimates that 23 million affected workers will experience a \$28 aggregate annual wage reduction. Vedder & Gallaway [10] estimate that the Clinton plan will decrease wages by \$93 billion in 1998, and the O'Neills [7, 8] estimate a \$27 billion wage reduction per year. The State of California [1] predicts a \$68 billion loss in wages per year.

While the lowest wage workers are most at risk to lose their jobs as the result of an employer health care mandate, workers making between \$14,000 and \$30,000 per year stand to suffer most of the estimated wage reductions, losing on average \$1,450 a year. Table 2 summarizes the major findings on the impact of an employer mandate on wages.

**Table 2 — Estimated Wage Effects of
An Employer Health Care Mandate**

Study Author/Organization	Annual Wage Loss (Aggregate)	Annual Wage Loss (Per Affected Worker)*
Office of Planning & Research/State of California [1]	\$ 68 billion	\$ 1,660
CONSAD Research Corp./NFIB [6]	\$ 28 billion	\$ 1,200**
O'Neill & O'Neill/EPI [3, 7, 8]	\$ 27 billion	\$ 660
Vedder & Gallaway/ALEC [10]	\$ 93 billion	\$ 2,300
AVERAGE	\$ 54 billion	\$ 1,450
* JEC/GOP staff calculation assumes 41 million affected workers.		
** CONSAD calculation assumes 23 million affected workers.		

Several of the studies also estimate the impact of an employer mandate on economic output. For example, DRI/McGraw-Hill [2] predicts that in the year 2000 GDP will be down by \$53 billion, and Fiscal Associates [9] estimates that GDP will fall \$90 billion by 1998 because of an employer health insurance mandate.

The studies in the Survey differ in crucial aspects. They employ different statistical models, different wage elasticities of labor demand and labor supply, and they treat premium-shifting by employers differently. The studies make different assumptions about the rate of growth of insurance premiums, and posit different levels of assumed savings from health care reform and other key variables. Yet, the studies' findings are consistent and unambiguous: **Employer Mandates Destroy Jobs — a lot of them. Employer Mandates Reduce Wages — a lot.**

CONSAD Research Corp. [6] examined five major plans introduced in the United States Congress and found that only the Clinton plan produces substantial effects on employment because it is the only plan that requires employers to pay workers' health costs. Moreover, Andrew Dick [26] examined the Hawaiian health care mandate of 1974 and found that the employer mandate in that state did not significantly expand insurance coverage to the uninsured.

TOP TEN STUDIES¹

SOURCE NO. 1

State of California, Governor's Office of Planning and Research. Above All, Do No Harm: The Clinton Health Plan's Economic Risks for California. Sacramento, CA, June, 1994, 29 pp., plus Press Release, Questions and Answers, and Executive Summary, 10 pp.

The net job impact of the Clinton health plan on California and the nation as a whole is examined. The study relies on three previous studies by the Congressional Budget Office (CBO), the Office of Management and Budget (OMB) and Lewin-VHI for estimates of the plan's effectiveness in containing costs (see Appendix). Based on these figures, the study uses estimates of 0 percent and 5

percent deviation from the plan's predicted savings. If the plan achieves its own predicted savings (i.e., 0 percent deviation), then the study predicts national job losses in 1998 of 2.6 million. If the plan falls short of those savings by just 5 percent, then the job losses in 1999 would be 3.7 million. Employment gains by the year 2000 attributable to savings in health care would offset some of these losses, leading to net job loss of 1 million (0 percent deviation) to 2.8 million (5 percent deviation). Job losses in California alone would range from 476,000 to 650,000 in 1999. These losses in California would exceed all the California jobs lost from defense cuts, and would postpone the California economic recovery by up to two years.

SOURCE NO. 2

DRI/McGraw-Hill. The Administration's Health Care Reform Plan: National Macroeconomic Effects. Washington, D.C., Citizens for a Sound Economy, February, 1994, 76 pp.

This study provides an incremental analysis for five aspects of the Clinton health plan. The analysis first considers the effect of imposing universal coverage, then examines the incremental impact of an employer mandate, the corporate assessment, additional taxes, and spending caps. Thus, some of the numbers presented here are

absolute estimates of the mandate impact, while other numbers are estimates relative to a simulation of universal coverage.

An employer mandate to provide health insurance for workers increases the costs of doing business. As a result, employers will try to shift the costs, either to lower wages or else higher prices. Consumers respond by cutting back on real spending for medical and non-medical goods and services, which has a negative impact on employment and GDP. By

¹ Arranged alphabetically within each section.

the year 2000, about 709,000 jobs will be lost due solely to the employer mandate. GDP also falls by \$53 billion compared to the universal coverage simulation due to the employer mandate. As a result of these negative effects, the Federal deficit (compared to the universal coverage simulation) will be \$20 billion larger in 2000, and \$51 billion larger over 1996-2000. Inflation will be higher as well: in 1999, the implicit price deflator will be 0.6 of a percentage point higher. Subsidies for premiums paid by employers will top \$42.4 billion in 2000, for a total subsidy cost of \$138 billion over 1996-2000.

SOURCE NO. 3

Lane, Julia. *Labor Demand Elasticities and Clinton Health Care Reform: Survey of the Relevant Literature*. Employment Policies Institute (EPI), with Foreword by Daniel Hamermesh. Washington, D.C., July, 1994. 8 pp.

This paper is a response to an Administration critique (by R. Reich and L. Tyson) of an O'Neill and O'Neill study of the Clinton plan. Overall, Lane's findings confirm that the labor market responses assumed in the O'Neill paper are well supported by mainstream economic thought and also conservative in that they represent the mid-point of accepted values. Her

findings (supported by Daniel Hamermesh) show that accepted economic thought on labor response calls for a reduction of between 1.5% and 7.5% for a 10% increase in costs. These figures bracket the estimates of 3% and 5% used by the O'Neills. Lane's findings reinforce the EPI position that the Clinton mandate would cost *at least* \$80,000 jobs.

Unlike most other researchers, Lane argues that the employer mandate is more like a lump sum tax on employment (roughly \$2,000 per employee) than an increase in the minimum wage. Thus, studies that have examined the effect of increases in wages (such as minimum wage studies) will have limited applicability. The more employers can substitute capital for labor, the more responsive they will be to increased labor costs. After outlining multiple approaches to measuring the homogenous (or economy-wide) elasticity of labor/capital substitution, Lane cites Hamermesh's overall view that a reasonable confidence interval is .15 to .75, with a reasonable point estimate of .30. Lane also considers the evidence on heterogeneous (or group specific) elasticity estimates, concluding that most estimates are between .3 and 2.0 for unskilled workers; between .2 and 1.0 for skilled workers; between 1.3 and almost 10.0 for teenagers; and between 2.5 and almost 4.0 for adult workers. Lane also cites Hamermesh as arguing that a health care mandate that extends coverage to nonworkers "does not have the advantageous supply side effects" of the minimum wage.

Since the Clinton plan essentially mandates a fixed premium for employers to pay, it imposes a fixed cost on employment rather than on hours worked. Intuitively, this should have different effects on employment and hours worked – firms would less likely to hire workers and more likely to extend the working hours of the currently employed. Unfortunately, as Hamermesh points out, not much is known about the substitution of

employment for hours. In general though, the results reviewed here suggest that jobs will indeed be affected more than hours worked. There is likely to be a substitution away from part-time workers and toward full-time workers, although the magnitude of this effect is impossible to determine given current data. There is no single "right" point estimate of the elasticity response of employers. Hamermesh suggests a range of .15 to .75, and Krueger uses a range of .25 and .75. Recent evidence from Dunne and Roberts suggests that these ranges might even be understated, and the effect on low-wage workers is likely to be greater.

SOURCE NO. 4

JEC/GOP Staff. Run from Coverage: Job Destruction from a Play or Play Health Care Mandate. Health Care Briefing Paper No. 5, April 9, 1992, 33 pp.

A "simple" pay-or-play health insurance mandate costing 7 percent of a firm's payroll will sacrifice over 710,000 lost jobs in the first year of implementation, 43 percent of which will occur in firms with fewer than 20 workers. Under the idealized assumptions that insurance industry reforms

are in place and medical costs are "controlled," the first-year payroll costs of a play-or-pay mandate would exceed \$87.8 billion in 1991 dollars, with about half from higher insurance costs or tax penalties and half from tax increases or higher Federal deficits. The national unemployment rate would increase by 0.76 percentage points, say, from 6 percent to 6.76 percent. Under the 7 percent payroll tax, the net effect on the Federal budget deficit is expected to reach \$18 billion over five years. If the payroll tax were 9 percent, job losses would reach 807,000; at 20 percent, job losses would top 1.2 million.

SOURCE NO. 5

Klerman, Jacob Alex. RAND Corp. Job Loss Due to Health Care Reform. Oral statement before the United States Senate, Committee on Labor and Human Resources. October, 1993.

In his testimony, Klerman asserts that the job loss directly caused by the employer mandate would be small, on the order of one-half of one percent of total employment, or about 600,000 jobs. (Also see Source 16.) The mandate would cause firms to lower their wages, thus hurting low-wage workers but this effect would be mitigated by subsidies. Contrary to the expectations of most economists and textbook theory, some recent case studies of the increases in the minimum wage fail to find any employment loss due to the increase in the minimum wage. Econometric studies over longer time periods attribute measurable, but small, job losses to changes in the minimum wage. Fundamentally, the lower estimate of job loss given here can be attributed to the assumption that wages are flexible downward. If health reform is successful in containing the rate of growth of health care expenditures, then there are likely to be positive employment effects. Two other labor supply points merit mention. First, guaranteeing insurance will likely induce some workers to leave the labor force, mainly because the primary reason for working was to obtain health care. Second, because the mandate will lower wages (as compensation rises), some workers will choose to work less.

SOURCE NO. 6

National Federation of Independent Business and the Healthcare Equity Action League. Employment and Related Economic Effects of Health Care Reform, Pittsburgh, PA. Prepared by CONSAD Research Corporation, April 1994, approx. 108 pp.

Although this study considers five prominent reform plans, only the Clinton plan will produce substantial job loss, as well as large numbers of workers who will suffer reductions in wages. An estimated 850,000 jobs will be lost in the first few years of operation. Estimates of job losses as high as 1 or 1.3 million are not unreasonable. An estimated 23 million workers will see their wages reduced, with an average reduction of \$1,200 per year. Of the 850,000 lost jobs, firms with under 500 employees will account for 470,000 of the lost jobs and 16 million of the 23 million workers with reduced pay. Federal subsidies to businesses will amount to \$81 billion in 1996. If the alliance premiums do not realize the savings estimated by CBO, then the business subsidy could reach \$120 billion in 1996. If no subsidy is provided to businesses, then the job loss figure could jump to 3.8 million.

The CONSAD model uses three estimates of cost shifting, beginning with 100 percent of mandated costs paid by employers. The second scenario holds that employees whose

premiums increase under the Clinton plan will suffer an equal offsetting decrease in wages. In the third and most likely scenario, the first two scenarios are combined: employers pass the entire increase in health costs to workers with wages of \$12.50 an hour or more by decreasing their wages, while no costs are passed onto minimum wage workers. There are two scenarios for the elasticity of demand for labor. The first one assumes a constant value of (-2) for all industries. The second scenario uses different values for each industry, with an average value of (-2).

SOURCE NO. 7

O'Neill, June E., and Dave M. O'Neill.
**Effects of the Employer Mandate in the
 Clinton Health Plan.** Washington, D.C.,
 EPI, March 1994, 23 pp.

The Clinton health plan could result in job losses of 780,000 to 890,000. Unless national expenditures on medical services are brought under control, job losses could go as high as 2.3 million. The Administration argues that job loss from its reform will be just .5 percent of total

employment, yet the O'Neill estimates are substantially higher. The Clinton plan's mandate would require that employers cover an additional 45 million workers, although 60 percent of these workers are currently covered through other means such as a spouse's employer provided policy. Only about 18 million workers would actually gain coverage through the mandate. While employers can pass on some of the costs, approximately 20 million of these workers earn wages that are too low to be legally or feasibly reduced. This is where the job impact of the Clinton mandate tax would hit the hardest. Even if the Clinton plan would realize the savings it predicts, approximately 4 percent of these low-wage workers, or about 800,000, would lose their jobs. If the savings in Medicare, Medicaid and other federal programs to pay for government subsidies is not realized, then the job loss impact for these currently uninsured workers could rise to almost 11 percent of the 20 million low wage work force, or about 2.2 million. The CBO found that the Clinton plan would cost \$132 billion more than what the White House projects. Moreover, the plan's cost control depends on self-restraint by Congressional majorities to abide by the constraints the plan imposes on health care utilization, budgets and prices. Low-wage workers in large private firms would account for half of the total jobs lost. Some industries, such as restaurants and retail trade establishments, would experience much greater job loss than others.

The plan calls for employers to pay 80 percent of the insurance premiums and the additional cost of the mandate to employers would be about \$87 billion, of which \$33 billion would be rebated through subsidies from the Federal government. Employers who currently provide insurance to their workers would experience reductions in premiums amounting to \$18 billion – about \$6 billion through government rebates and \$12 billion through other features of the plan. The government subsidies, of course, must have a revenue source, either in the form of "savings" from reforms, new taxes or deficit spending. The mandated premiums would impose an average 16 percent increase in the compensation an employer must pay for an uninsured worker. In low wage industries, the increase could be as high as

25 percent.

The O'Neills' review of the literature suggests that the compensation increases resulting from a mandate could be expected to generate a response elasticity of (-.3) for the economy as a whole, although significant differences in responses may be occur in heavily impacted industries like retailing and personal services.

If the Clinton plan were implemented without any business subsidies, the average annual premium cost per uninsured worker would be \$1,923, or 13 percent of their average annual wage. Within specific industries, the increases would be 22 percent in Eating and Drinking; 20 percent in Agriculture; 16 percent in Other Retail; and 19 percent in Personal Services. Even with the government subsidies, wage costs would still rise 8.5 percent for currently uninsured workers.

With moderate shifting of premium costs to workers, the aggregate job loss would range from 300,000 to 2.3 million, depending on assumptions. With minimal shifting, the range goes from 500,000 to 3.6 million. Wage elasticities of (-.1), (-.3) and (-.5) are used. Under what the authors consider reasonable assumptions (Foster Higgins premium costs; an elasticity of (-.3); and moderate (70 percent) cost shifting), the job loss without business subsidies would be 2.2 million among the uninsured workers newly covered by the mandate. With subsidies, the job loss would be about 780,000.

SOURCE NO. 8

O'Neill, June E., and Dave M. O'Neill.
**The Employment and Distributional
 Effects of Mandated Benefits.**
 Washington, D.C., American Enterprise
 Institute, 1994, 33 pp.

This study is derived from the previous two reports by O'Neill and O'Neill, both published by EPI, and is based on the most recent detailed version of the Clinton plan. The authors make many of the same points as in Source 7: even with subsidies, job losses could go as high as 900,000; the wages of once-uninsured workers would

decline by a net average of 6 percent; and Federal expenditures would be \$40 billion higher in 1994 if the plan had been in effect. For the authors' most likely scenario simulation, 70 percent of the cost of new premiums will be shifted to workers among the currently uninsured and they use a wage elasticity of labor demand of (-.3). Ehrenberg and Smith report that changes in labor costs economy-wide appear to be associated with a total response elasticity of that could be as high as (-.75). Assuming an elasticity of (-.3) and cost shifting of 70 percent to employees, and using the Foster-Higgins survey data on premiums, the job loss under the Clinton mandate could be 2.2 million (Table 5).

SOURCE NO. 9

Robbins, Gary, and Aldona Robbins.
Forecasting the Effects of The Clinton
Health Plan. Dallas, TX, National
 Center for Policy Analysis, May, 1994, 38
 pp.

Using the NCPA/Fiscal Associates Health Care Model to assess the effect of the Clinton health care proposal without rationing, this study finds that GDP would fall by \$123 billion per year because health care output would increase by \$21 billion over baseline and other output would fall by \$144 billion. By the year 2000 there

would be a loss of 677,000 jobs and the stock of U.S. capital would decline by \$378 billion. By the year 2005, annual GDP would be \$132 billion lower than otherwise, the U.S. capital stock would be \$302 billion lower and there would be 179,000 fewer jobs. The Federal budget deficit would increase the Federal deficit by \$452 billion over the next decade.

With rationing, by the year 2005 annual GDP would be \$61 billion lower, the U.S. capital stock would be \$345 billion lower and there would be 109,000 more jobs than otherwise.

The intermediate forecast shows that the Clinton plan would reduce the annual value of consumption per household by about \$1,000 per household.

SOURCE NO. 10

Vedder, Richard, and Lowell Gallaway.
Concealed Costs: The Real Impact of the
Administration's Health Care Plan on
the Economy, A State-by-State Analysis.
 Washington, D.C., American Legislative
 Exchange Council, March 1994, 21 pp.

A decline in personal income due to the Clinton health plan, estimated at \$112 billion in 1998, will result in substantial revenue loss for state and local government. More than \$17.6 billion in state and local revenues would be lost annually by 1998, and the Federal government would lose \$25 billion annually. The Clinton plan would have an adverse fiscal impact in 48 of 50

states.

Nationwide, the study estimates that over 1 million jobs would be lost due to increased labor costs, and wage payments would be reduced by over \$93 billion. The net present value of the cumulative loss in income over the next 25 years is predicted to exceed \$2 trillion. Allowing for growth in employment between now and 1998, the Clinton plan would reduce employment by about .8 percent per year nationally. The proposed \$0.75 tobacco tax would result in an additional 272,000 lost jobs. Overall, labor costs would rise 2.53 percent on average, based in part on the 1992 JEC/GOP study. The study assumes

that 85 percent of the monetary impact is observed in reduced wages, and 15 percent in reduced employment, consistent with most similar studies. Using standard quarterly data, they derive a long-run elasticity of demand for labor of $(-.83)$. After adjusting for the wage reduction effect of the employer mandate on labor, the authors arrive at a net elasticity of disemployment with respect to the insurance mandate of $(-.31)$. Although in a free labor market 85 percent of the costs would be shifted to employees, other factors such as minimum wage limit the wage adjustment factor to an estimated .62.

USEFUL SOURCES

SOURCE NO. 11

Pauly, Mark. **But Will It Work in Theory? How to Improve the Clinton Health Plan by Converting the Employer Mandate into an Employer-Enforced Individual Mandate.** Princeton, NJ. Paper presented at the Conference "Universal Health Coverage: How Do We Achieve It? Employer Mandates vs. Individual Mandates." January 28-29, 1994, 19 pp.

This paper observes that mandates are taxes, and argues in favor of an individual mandate to buy health insurance. It claims that direct, explicit taxes (i.e., an individual mandate) to pay for health insurance is better than indirect, implicit taxes (i.e., employer mandate) because direct taxes are easier for citizens to understand, easier to tailor to the income/wealth levels of individuals, and cause less distortion than indirect taxes. In strict economic theory, there is little difference between the individual and employer mandates.

Minimum wage workers aside, mandates reduce wages rather than employment. However, this assumes that money wages are flexible, which does not seem to be true in the short run or for minimum wage workers. The paper concludes with a discussion of why an individual mandate is more advantageous and less economically harmful than an employer mandate.

SOURCE NO. 12

Danzon, Patricia. Global Budgets vs. Competitive Cost Control Strategies or Oil and Water Don't Mix (Except as Pollution). Washington, D.C. Paper prepared for the American Enterprise Institute Conference on Budget and Regulatory Aspects of the Clinton Health Care Plan, February 22, 1994, 18 pp.

This study claims that the competitive approach to health care reform includes three aspects: mandated coverage, government subsidies, and insurance regulation. In general, the study endorses a competitive framework which rejects both global caps and the current tax exclusion of employer provided benefits. In the long run, employer contributions to health benefits are shifted to workers in the form of lower wage rates if job opportunities are to remain unaffected. In the long run, the financing of the plan is paid for 100 percent by employees through lost jobs and lower wages. It would be political suicide to propose a plan that explicitly mandates that everyone buy coverage as comprehensive as that selected by a minority of large firms under the current tax subsidy. Yet, the Health Security Act attempts this feat implicitly by using a variety of political ruses to obscure the fact that ultimately workers pick up their own health insurance tab. Critical to making this strategy politically feasible are the employer mandate, to hide real cost from voters, and global budgets, to hide the magnitude of the potential cost of the new entitlement.

SOURCE NO. 13

Davis, Karen. Achieving Universal Health Insurance: Financing through Taxes, Employer, or Individual Premium Mandates. Princeton, NJ. Paper presented at the Conference "Universal Health Coverage: How Do We Achieve It? Employer Mandates vs. Individual Mandates." January 28-29, 1994, 25 pp.

This paper is a collection of charts and tables covering all aspects of health care reform. It lists the advantages of employer insurance mandates as: minimizing Federal budgetary cost; building on current system; leveling the "playing field" across firms; being administratively enforceable; and making premiums affordable for workers. The disadvantages include: possible adverse employment effects on low-wage workers; possible financial failure of some

small businesses; regressive financing source; and firms in higher health care costs areas pay higher premiums. The paper finds that under the Clinton plan only 34 percent of private employers who now offer insurance will see annual per worker expense increase by \$500 or more and that 44 percent of such firms will experience a decrease in annual per worker costs of \$500 or more.

SOURCE NO. 14

Dick, Andrew W. Will Employer Mandates Really Work? Another Look at Hawaii. *Health Affairs*, Spring (I), 1994, pp. 343-49.

This statistical analysis shows that the Prepaid Hawaiian employer health care mandate enacted in 1974 did not significantly expand insurance coverage to the uninsured. The state's high rates of coverage are due largely to the characteristics of Hawaii's population.

Similar business mandates elsewhere would produce only a small reduction in the number of uninsured persons.

There are two explanations for the poor performance of the employer mandate in Hawaii. First, the 1974 mandate does not target many of the uninsured because it exempts part-time workers and seasonal agricultural workers and does not require coverage of employees' dependents. Second, many persons covered by the mandate remain without insurance, indicating that noncompliance is a substantial problem.

Since the Hawaiian employer mandate has had relatively little effect on extending coverage to the uninsured, the state's experience sheds little light on the probable impact of a strongly enforced national business mandate on jobs, wages and economic growth.

SOURCE NO. 15

Feldstein, Martin. The Health Plan's Financing Gap. *Wall Street Journal*, September 29, 1993, A18.

The financing of the Clinton health plan has serious flaws for two primary reasons: Medicare/Medicaid savings will be less than predicted and the public's utilization of medical services will be greater. The 7.9% payroll premium functions as a tax on incremental wages. Calculations with the

NBER-TAXSIM Model imply that this new payroll tax would cause changes in behavior that reduce total 1997 wages by about \$115 billion and cut the federal government's tax revenue by \$49 billion. After accounting for other revenue shortages, excess Medicare/Medicaid spending, and increased utilization, the federal financial shortfall reaches \$120 billion in 1997. The TAXSIM Model shows that to make up this \$120 billion would require increasing marginal tax rates by at least 24% even if those higher tax rates only reduced output and taxable income and wages by as little as 2%. A taxpayer who is now paying a 15% marginal rate would face a rate of 18.6%. A taxpayer at the current top rate of 39.6% would see that rise to 49% or higher.

SOURCE NO. 16

Klerman, Jacob Alex, and Dana Goldman. *RAND Corp. Job Loss Due to Health Care Reform*. Written testimony to the United States Senate, Committee on Labor and Human Resources, October, 1993.

This paper, submitted in conjunction with Klerman's oral statement to the Congress, argues that for employers of low-wage workers, the employer mandate in the Clinton plan is in effect an increase in the minimum wage. After this mandate is implemented, firms can change their behavior in four ways: lower profits, raise prices, reduce worker wages, or reduce employment. Recent experience with other

employer benefit mandates suggests that much of the increased costs to firms will be passed on to workers in the form of lower take-home pay. Jonathan Gruber and Alan Krueger find that firms pass on approximately 85% of the increase in compensation in the form of lower wages within a few years. Because of this backshifting onto wages, they find little evidence of a significant decrease in employment. From the perspective of the working poor, the Clinton plan is regressive. The argument that workers bear the cost of lower wages breaks down for very low-income workers. The employer mandate would raise wage costs by \$1.00 to \$2.00 per hour depending on family composition. Standard economic theory suggests that firms will cut employment until the remaining workers are each worth \$5.25 to \$6.25 per hour, while some workers below \$6.25 will lose their jobs.

The authors criticize the 1993 O'Neill and O'Neill study on four grounds: the choice and application of a 0.3 elasticity is unrealistic; the assumption that only 50% of the burden is passed on to workers; the estimate of premiums 25% higher than the Clinton estimates; and a failure to account for firm subsidies.

Using two sets of elasticities and three levels of firm subsidies, the authors estimate the job loss under the Clinton plan. For a demand elasticity, they find most credible the Neumark and Wascher (1992) estimate of .17. They also believe that a cap of 7.9% of payroll, as promised in the Clinton plan, is most realistic. Total job loss, in the authors' most likely scenario, is 0.49% of total employment, or approximately 600,000 jobs. This estimate does not consider indirect employment effects. A positive effect can be expected as health care costs decrease and the relative incentive for recipients to stay on welfare and Medicaid declines. On the negative side, employment may decrease as people who were working primarily to obtain health insurance leave the work force and as the decrease in wages reduces the incentive to supply labor. The estimates of job loss are low because the authors expect that firms will successfully pass on the cost of their share of health insurance premiums to their employees in the form of lower wages. Given that real wages for low-skilled workers have fallen considerably over the last two decades, the assumption of downwardly flexible real wages seems plausible. This factor, however, makes the legislation significantly regressive, an effect which might be offset with federal subsidies.

SOURCE NO. 17

Lee, Dwight R. *The Misguided Policy of Mandated Benefits*. St. Louis, MO, Center for the Study of American Business, *Contemporary Issues Series No. 58*, April 1993, 22 pp. (This essay also appeared in *Society*, May/June 1994: 14-19).

This analysis observes that the cost of mandated benefits is paid primarily by the workers, and that the cost of these benefits to the workers is generally greater than the value they place on the benefits financed, with the greatest harm suffered by low-skilled young people. Although the competitive global economy is increasing the importance of well-trained and educated workers, mandated benefits tend

to decrease the opportunities for on-the-job training. Low skilled workers are big losers from mandated benefit legislation because they have so little to give up, other than their job. Lee refers to the JEC/GOP study which shows that the "pay or play" health plan could eliminate over 710,000 jobs. Moreover, laws which put low-skilled young people out of work can be expected to increase criminal "employment" as a consequence of the reduction in their opportunities for productive employment. A 1987 study by M. Hashimoto found that for each 10 percent increase in the minimum wage, the ratio of teenage arrests to total arrests increases by 1.5 percent to 3 percent, depending on the type of crime.

SOURCE NO. 18

Krueger, Alan, and Uwe Reinhardt. *A Primer on the Economics of Employer vs. Individual Mandates: Theory, Evidence and a Compromise*. Princeton, NJ. Paper presented at the Conference on "Universal Coverage: How Best to Achieve It? Employer Mandates vs. Individual Mandates." January 28-29, 1994, 21 pp.

Universal coverage requires some form of a mandate. Those who would mandate that all businesses provide their employees with health insurance do not do so on the basis of economic principles. More probably, they do so as a political expedient. According to the authors, an employer mandate is not really a "tax" except in the sense that economists use the term. The paper outlines the fundamental economic theory behind labor markets, relying on supply and demand graphs. The authors

show that if the demand for labor is not wage-sensitive, then the wage and employment reductions caused by an employer mandate would be relatively small. The authors claim that the available empirical literature has yielded large ranges for these wage sensitivities. Most studies show that the incidence of an employment-based mandate falls mainly on employees. The authors review the findings of a number of studies. They simulate a proposed mandate, and claim that the employer mandate is quite a bit more progressive than the individual mandate they choose to compare it with. (The Clinton plan mandate would be less progressive than the model tested here.) The authors conclude that the net

incidence of an individual and an employer mandate on individual households are probably not too dissimilar. They recommend a social-insurance approach like that of the Social Security payroll tax, which would eliminate the distortive notch effects now in Clinton's plan.

SOURCE NO. 19

McArdle, Frank B. How Would Business React to an Employer Mandate? Princeton, NJ. Paper presented at the Conference on "Universal Coverage: How Best to Achieve It? Employer Mandates vs. Individual Mandates," January 28-29, 1994, 33 pp.

There does not appear to be a single opinion among employers on a mandate. Most executives find an employer mandate for coverage of basic services either "somewhat acceptable" or "somewhat unacceptable." Business opposition will increase as the financial burden and the uncertainty of the burden rise. A major sticking point is the treatment of full-time versus part-time workers. The author

argues that given estimates of administrative expenses for small employers running anywhere between 25 percent and 40 percent of insurance premiums, administrative simplification could decrease employer opposition to the mandate. Large employers face much lower administrative costs. The main reason an employer mandate enjoys some political popularity is "because it is a way of funding a sizable portion of the incremental cost of universal coverage without a direct tax increase or a direct Federal budgetary effect... We are talking about increasing the economic obligation, about an additional economic burden."

SOURCE NO. 20

Mitchell, Daniel J. The Economic and Budget Impact of the Clinton Health Plan. Backgrounder No. 974, Washington, D.C., Heritage Foundation, January 13, 1994, 10 pp.

This report claims that the economic and budget impact of the Clinton plan will be severe, including fewer jobs and lower wages. When employers calculate whether they can afford to hire new workers or raise the take-home pay of existing workers, they consider the total cost of such decisions, including all forms of compensation,

mandates and taxes. A new mandate, requiring firms to "contribute" most of the premium for an expensive health insurance package, will weigh in these decisions if a Clinton-type employer mandate is enacted. The Administration itself admits that the plan could destroy 600,000 jobs in the early years alone. One-third of small businesses would reduce the number of full-time employees if they faced a health insurance mandate, according to a 1993 seven-city survey of 2,400 businesses. Also, four out of five economists in a 1,000-member survey of the American Economic Association predicted a decline in low-wage employment in response to a mandate. Eighty-five percent of mandated benefit costs would be paid by workers in the form of lower wages according to a 1991 National Bureau of Economic Research study.

SOURCE NO. 21

Moore, Michael D. **Feasibility of Universal Coverage Under Managed Competition Using Combined Individual and Employer Mandates: A Draft Discussion Paper from the Jackson Hole Group.** December 1993, 16 pp.

This paper evaluates the pros and cons of a combination of individual and employer mandates compared to a single mandate. Page 5 summarizes the advantages and disadvantages of a combined mandate over just an employer mandate. Pages 6-7 summarize the pros and cons of the combined mandate compared to the individual mandate. The effect on total

system costs (page 11) would depend on a number of factors. While covering the uninsured may increase total system costs, it may not increase costs very much since the uninsured currently receive about two-thirds of the health services of the insured and substantial uncompensated care costs are already in the system. The combined mandate could be budget neutral for the Federal government, depending on the nature of the benefits package and the extent of subsidization.

SOURCE NO. 22

Pfleeger, Janet, and Brenda Wallace. **Health Care Alternatives: Employment and Occupations in 2005.** *Monthly Labor Review*, (April 1994): pp. 29-37.

This paper presents the results of a BLS study analyzing changes in employment within the health care industry and in other industries. There are three different scenarios, each positing a different level of spending on health care services. Essentially, when GDP is assumed constant,

increases in health care spending (which generate increases in health-related employment) come at the expense of spending and employment in non-health industries. Specific predictions for low, moderate and high health sector growth are offered. Decreases in health care spending (the goal of health care reform) translate into decreases in health related employment with concurrent increases in spending and employment outside of health care. When GDP is assumed to change, the analysis predicts the aggregate impact of the three health-related spending levels, as well as the secondary effects of health care spending on non-health industries.

SOURCE NO. 23

Richardson, Craig. **Clinton Plan's Perverse Incentives.** *Wall Street Journal*, March 15, 1994, p. A20.

Richardson documents the peculiar labor "cost spikes" or "notches" built into Clinton plan. Under the proposed tax and subsidy scheme, it would cost a small business paying an average annual wage of \$15,000

a net of \$660 per employee for health insurance coverage for each worker up to 24 employees. Hiring the 25th worker, however, would cost the firm \$4,035 per year in health insurance expenditures. There are similar cost spikes of \$7,545 for the 50th worker and \$20,310 for the 76th worker because the payroll percentage rate caps are average payroll rates for each employment class rather than increased rates that apply to each size class. That is, when a company crosses into a higher category, it must pay a higher percentage for all its employees, not just the additional hire.

The Clinton plan rewards companies that stay small, split themselves into two or more smaller companies, fire employees and explore other creative methods to play the system for premium subsidies. The result is economic segregation, fewer jobs, and lower output and wages.

SOURCE NO. 24

Rivlin, Alice, David Cutler, and Len Nichols. *Financing, Estimation, and Economic Effects. Health Affairs, Spring(1994): 30-49.*

This article, co-authored by Clinton's Deputy Director of OMB, Alice Rivlin, offers a favorable financial analysis of the Clinton health plan, a plan which, according to the authors, preserves what is best in the current system while controlling costs and providing universal access to health care.

Under the Clinton plan, three-fourths of total health insurance would still come from the private sector. The Clinton health plan would make a net contribution of \$58 billion to reducing the federal budget deficit over six years. Allegedly, no firm will have to pay more than 7.9% of payroll for insurance. Given the well-known shortcomings of the health care markets in the United States, many economic features of the Clinton plan will enhance efficiency. According to the authors, much of the negative rhetoric is overblown. There are costs to the mandates, but there are also benefits, in terms of lower costs to many people and increased security. In fact, through 1998, the employer mandate results in little net change in employer premium spending, as the costs of universal coverage are offset by savings to the currently insured. By 2000, total employer payments are forecast to be approximately \$25 billion below current spending levels, a 5.4% reduction. On average, employers are expected to save \$233 per worker by 2000. Costs increase by an average \$1,292 per employee for firms that do not currently insure its employees compared to a \$610 decrease for firms that pay for health benefits. Most of the predicted cost savings are likely to be passed onto workers in the form of higher wages or other compensation. Empirical evidence suggests that 80%-100% of each dollar reduction in health care spending will translate into higher wages. Studies that have included some or all of the savings for workers find very different employment effects of reform than analyses that ignore this issue, with a range of 300,000 jobs lost to 600,000 jobs gained. Most of the large scale macroeconomic models commonly used to forecast aggregate economic changes agree with the conclusions of the Council of Economic Advisors in predicting that the Health Security Act will have little effect on total employment. Job losses are not likely to be large and

labor mobility should increase greatly. The article concludes with the statement: "The administration does not pretend to have divine wisdom on this issue."

SOURCE NO. 25

Steuerle, C. Eugene. *Economic Effects of Health Reform*. Washington, D.C., American Enterprise Institute, 1994. 24 pp.

This study examines the impact of health care reform on the Federal budget, labor market, income distribution, medical innovation, and the administration of health care. For the effect on the labor market, Steuerle observes that the mandate operates in some respects like an increase

in the minimum wage. If the worker's value of production is just at the minimum wage, then hiring or maintaining him can be done only at a loss. The mandate would, however, increase the labor supply of welfare recipients by reducing their disincentive to go off Medicaid to a low wage job without health insurance.

Low wage workers and households with more than one worker are most likely to be negatively affected by the mandate-caused losses in jobs. The mandate would also create an incentive for early retirement. Steuerle argues that the Clinton mandate could lead to the economic segregation of workers, with rich and poor workers increasingly separated by type of employer. Business subsidies would be to health policy what old-time public housing was to housing policy in its effect on economic segregation. There would be an incentive for low wage workers to migrate to subsidized small firms while high wage workers would cluster in firms that do not benefit from the subsidies. Under this system, individuals would respond by working or living not where they are most productive but where the subsidies are greatest.

SOURCE NO. 26

Steuerle, C. Eugene. *Employer and Individual Mandates to Purchase Health Insurance*. Princeton, NJ. Paper presented at the Conference "Universal Health Coverage: How Do We Achieve It? Employer Mandates vs. Individual Mandates." Princeton, NJ, January 28-29, 1994, 18 pp.

A mandate to purchase health insurance is equivalent in many ways to taxing individuals and then giving each of them an expenditure equal in value to the amount of tax paid. At their core, mandates are justified on the notion that it is unfair or inefficient for some in society to impose costs on others who are not as capable of bearing these costs. One of the consequences of an employer mandate, as well as of Medicare-type government plans,

is that the cost of insurance remains hidden from individuals. An employer mandate to provide insurance raises the effective minimum wage that an employer must pay. Most

economic analyses show that increases in the minimum wage tend to decrease employment at low wage levels, although there is much dispute about how large the effect may be. The adverse effects are more likely to be seen in smaller firms.

SOURCE NO. 27

Weidenbaum, Murray. *How Government Reduces Employment*. St. Louis, MO: Center for the Study of American Business, Contemporary Issues Series No. 61, December 1993, 24 pp.

Through legislative mandates on and regulation of employers, government laws and rules weaken the demand for labor and, often, the supply of labor as well. This pamphlet cites the 1993 O'Neill and O'Neill study showing a possible 3.1 million job loss, as well as the Alan Krueger study showing between 200,000 and 500,000 lost

jobs. Also cited is the Minimum Wage Study Commission, which documented that a 10 percent increase in the minimum wage increase unemployment among minimum wage workers (mostly teenagers) by 1-3 percent. Although several economists have reached similar findings, a distinguished trio of economists (David Card, Alan Krueger, and Lawrence Katz) have recently come up with a contrary conclusion: they find in empirical studies that the 27 percent increase in the minimum wage in April 1990 had virtually no negative employment effect.

GENERAL BACKGROUND SOURCES

SOURCE NO. 28

Addison, John T., and McKinley L. Blackburn. *The Effect of Recent Increases in the U.S. Minimum Wage on the Distribution of Income*. Washington, D.C.: Employment Policies Institute, March 1994, 32 pp.

The authors examine the increase in the Federal minimum wage from \$3.33 to \$4.25 (a 27 percent increase) that took place in 1990-91. They find no evidence that the increase affected the poverty rates of those groups who supposedly benefit from the minimum wage. Minimum wage increases may lead employers to make greater use of part-time labor.

SOURCE NO. 29

Albright, James A., Eugene E. Bleck, and Rita Ricardo-Campbell. *Health Care in the United States: What We Should Keep and What We Should Change*. Stanford, CA. *Essays in Public Policy*, the Hoover Institution, Stanford University, 1994, 22 pp.

This policy paper endorses medical savings accounts, an overhaul of medicaid, and increased consumer information and responsibility.

SOURCE NO. 30

Bauman, Robert E. *70 Years of Federal Government Health Care: A Timely Look at the U.S. Department of Veterans Affairs*. Washington, D.C. The Cato Institute, Policy Analysis No. 207. April 27, 1994, 27 pp.

This essay outlines the major problems the VA has in delivering medical services. Most notably, 90 percent of veterans choose private alternatives when possible and lengthy waiting lists are not uncommon, even for routine medical treatments.

SOURCE NO. 31

Feldstein, Martin. *Clinton's Hidden Health Tax*. *Wall Street Journal*, November 10, 1993. A20.

Feldstein observes that "everyone knows that a government requirement to pay money is a tax." The key point is that the true costs of taxes – including the part that is labeled a "required employer premium" – would be borne by employees in the form of lower wages. Not calling this mandate a

tax is more than just spin control. It would also keep the tax out of the budget and would not require congressional action to raise in the future.

SOURCE NO. 32

Fuchs, Victor R. The Clinton Plan: A Researcher Examines Reform. *Health Affairs*, Spring (1994): 102-14.

Fuchs opens with a quote from George Stigler: a scholar "ought to be tolerably open-minded, unemotional, and rational. A reformer must promise paradise if his reform is adopted. Reform and research seldom march arm in arm." This paper

examines a number of health care "myths" and critiques the Clinton plan. One of these "myths" is that "Employers pay for health care." Over time, the rising cost of health insurance inevitably reduces the potential earnings of workers or results in higher prices to consumers. The negative impact on wages is readily evident. Between 1970 and 1980, total compensation (wages plus benefits) per hour of work rose 12% after adjustment for inflation. During that same time period, real wages fell by 6%. The reason benefits have increased so greatly is that benefits are "tax-free." Fuchs identifies three issues which must be addressed by any health care reform: we must disengage health insurance from employment; tame the costs of technological change; and learn to cope with an aging society.

SOURCE NO. 33

Herzlinger, Regina. The Quiet Health Care Revolution. *The Public Interest*, (Spring 1994): pp. 72-90.

This article documents how the massive entrepreneurial revolution that has greatly increased the health care system's efficiency is now in danger of being suffocated by government control. Entrepreneurs have introduced innovation in the form of new

organizations and new technologies. Managed care organizations, such as HMOs, do genuinely lower health care costs, but they do so more by rationing care than through entrepreneurial innovation. Of the three major approaches to health care reform (single-payer, managed competition, and consumer choice), only the last one will preserve and promote the entrepreneurial revolution which is in fact lowering costs.

SOURCE NO. 34

JEC/GOP Staff. Putting People Out of Work: First-Year Growth and Employment Effects of the Clinton Plan. August 1992, 23 pp.

This paper evaluates the various economic aspects of the Clinton economic plan. Part of the plan, the pay-or-play health care mandate, would cause over 710,000 jobs to be lost (cited from the earlier JEC/GOP staff study *Run From Coverage*). In addition, it considers a Democrat proposal

to index the minimum wage to the CPI, a move which would cost 42,000 entry-level jobs in

the first year. An alternative proposal, which would set the minimum wage equal to 50 percent of the average private, non-supervisory, nonagricultural hourly wage, is estimated to cause over 360,000 lost jobs.

SOURCE NO. 35

Mark, Tami L., and Denise Dougherty. Understanding Estimates of National Health Expenditures Under Health Reform. Washington, D.C., Health Program, Office of Technology Assessment, External Review Draft, February 2, 1994. Approx. 159 pp.

This study reviews the results, assumptions, and methodologies of a wide range of health reform reports. The authors emphasize the importance that different assumptions about critical variables can play. Although the study does not directly address the cost of employer mandates, it estimates a \$20-31 billion increase in spending on the newly insured, a 57 percent-93 percent increase.

SOURCE NO. 36

Robbins, Gary, Aldona Robbins, and John Goodman. Inefficiency in the U.S. Health Care System: What Can We Do? Dallas, TX, National Center for Policy Analysis, Policy Report No. 182, April 1994, 24 pp.

This study addresses the role of the third-party payment system in increasing overall health expenditures. Standardizing third-party payment shares would reduce health care spending by about \$139 billion without any reduction in the quality of care, and increase non-health care output by about \$155 billion.

SOURCE NO. 37

Ture, Norman B. The Clintons' Health Care Reform Plan Would Increase Health Care Costs. Institute for Research on the Economics of Taxation, Washington, D.C., Economic Policy Bulletin No. 62, March 16, 1994, 8 pp.

This paper highlights the role of government programs in distorting the health care market. In particular, employer-provided health insurance hides the true costs from the employees, thereby pushing up consumption of health care services.

SOURCE NO. 38

U.S. General Accounting Office, Health Care in Hawaii. February 1994. GAO/HEHS-94-68. Washington, D.C.: Government Printing Office.

Hawaii has the highest level of insurance coverage of any state in the nation. Estimates of the percentage of Hawaii's residents lacking health insurance in 1991 ranged from 3.75 to 7.0 percent in comparison to the national average of about 14 percent. Nevertheless, Hawaii's

employer mandate and government programs do not ensure universal coverage. Further, there are access problems and Hawaii has experienced the same rate of increase in health care costs.

Hawaii is the only state to require employers to provide health insurance to their workers through the 1974 Prepaid Health Care Act. Hawaii built on a strong tradition of employer based health benefits, partly due to the major role of labor unions in the work force, as well as Hawaii's history of plantation-provided medicine in which large plantations employed physicians to provide free health care to their workers. While the mandate did not cause large dislocations in the small business community, distinctive factors in Hawaii like its tradition of employer provided benefits, higher percentage of insured, and the lower cost of providing insurance in the mid-1970s, make generalizing its experience to the United States in the 1990s risky.

SOURCE NO. 39

Weidenbaum, Murray. Restraining Medicine Prices: Controls vs. Competition. St. Louis, MO, Center for the Study of American Business, Policy Study No. 116, April 1993, 26 pp.

This study of pharmaceutical prices concludes that the extended regulatory procedures of the FDA increase pre-tax costs by \$231-\$359 million per successful "new chemical entity" and that price controls have an unrelieved history of failure in the United States.

APPENDIX

CBO¹ and Lewin-VHI² have done studies of the Clinton Health Care Proposal that focus on the financial impact of the plan. Neither study estimates the employment and wage consequences of an employer health insurance mandate, although both studies imply that the disemployment effects are likely to be small.

CBO claims that "the Administration's proposal would probably have only a small effect on low-wage employment" (p. 60). Lewin-VHI, Inc., a prominent health care consulting firm in Fairfax, VA, estimates that the mandate would raise labor expense for firms not now offering health insurance by \$50.4 billion, partly offset by \$21.1 billion in subsidies, but the "analysis does not take into account the potential impacts of reform on employment, international competitiveness, and general productivity growth" (p. ES-16).³

Both studies assert small disemployment effects on the basis of two questionable assumptions: 1) The federal government will provide adequate subsidies to those businesses most affected by the mandate to relieve them of the need to take action on their own -- either job destruction or wage reduction; and 2) Government price controls on insurance premiums will be almost completely effective (85%-100%). To the extent that federal subsidies and price controls do not entirely compensate employers for their higher wage bills under the Clinton mandate, these two studies assume that employers will be able to shift the uncompensated cost increase onto workers in the form of reduced wages.

While these studies imply that job losses would be minimal because the additional cost of health insurance premiums would be largely absorbed by lower wages and slower growth in wages, CBO also points out that government-fixed premiums independent of age and health status (so-called community rating) would "cause an enormous redistribution of resources among workers in different industries" (p. 54), layoffs in firms that could not absorb higher costs, and large scale transitory unemployment as workers reshuffled among firms newly segregated by employment size in order to take advantage of subsidies (pp. 60-65).

¹ Congressional Budget Office, *An Analysis of the Administration's Health Proposal*, February, 1994.

² Lewin-VHI, Inc., *The Financial Impact of the Health Security Act*, December 9, 1993.

³ NFIB/CONSAD claims (p. 522) that Lewin-VHI puts the job losses at 129,000 to 285,000 but we have been unable to verify this claim with Lewin-VHI documentation.

ADDITIONAL VIEWS OF SENATOR JIM JEFFORDS

On June 9, 1994, I joined 10 of my colleagues on the Senate Labor and Human Resources committee in voting to favorably report S. 1779, the Health Security Act of 1993. I did so because it fulfills my own goals for health care reform, including universal coverage and shared responsibility between individuals, business, and government. Our deliberations during the mark-up process were held in open sessions before the American public and I commend the Chairman for his fairness and my colleagues on both sides of the aisle for the tenor of the debate. Many philosophical differences were aired, and many contentious issues were thoughtfully discussed. Although I do not support all of the provisions in this bill, I believe we have made progress towards a bill that can obtain broad bi-partisan support in the Senate.

I am pleased to support a bill that has laid a strong foundation for many priorities and programs which I think are key elements of successful health care reform. These provisions begin to answer problems of access, many of which may help to control costs in the overall system by promoting health.

The focus on preventive care and wellness in this bill is a significant step in refocusing our nation's health care priorities from just treating the sick to keeping people well. By including comprehensive preventive service benefits, incentives for workplace wellness programs, grants for National Prevention Initiatives and other provisions, this bill goes a long way to establishing a system that encourages people to stay healthy. One exceptional example of this emphasis is full funding for the Women, Infants and Children feeding program.

The additional funding for core public health functions is another facet of prevention, but on a societal level. Although the health care debate focuses on personal health care services, we must not neglect the public health systems that safeguard our environments and provide a host of functions to foster a healthier population. Federal funding for these functions currently comes in a vast array of funding streams from the Centers for Disease Prevention and Control, leading to duplicative administrative functions and a lack of coordination between programs. I believe the proposals in this bill to institute a standard application form and uniform reporting system for public health grants, and studies to look at creating a public health block grant for states, will improve the efficiency and effectiveness of the public health system.

Expansion of school-based health services and health education programs will encourage our children to live healthier lifestyles and make health care services more accessible to them. By providing comprehensive health education and having services readily available for students, schools will offer an environment conducive to meeting a wide range of health care needs. Equally important

is that these grants encourage school-based health services to become integrated with the health care resources of the broader community.

I have long believed that tremendous savings can be realized by our society by treating people with mental and substance abuse disorders in parity with other medical conditions. Many businesses have discovered that, by amending their benefits plans and instituting a managed care approach to mental health and substance abuse treatment, they have begun to show significant savings in the benefit expense itself. Social cost savings come from the reduction of juvenile crime and increased productivity in the workplace. Savings should also accrue through decreased medical utilization when mental health and substance abuse services are made available to patients who need them. I believe the benefits included in our bill will lead to the realization of many of these savings.

Finally, this bill was very thorough in acknowledging and accommodating the special concerns of rural and medically underserved areas. The different needs, resources, and priorities of these areas underscore the necessity for flexibility and innovation under comprehensive reform. A variety of resources will be needed to build an infrastructure in rural areas that is adequate to meet the needs of their inhabitants. Many programs were included in the bill that will do just that: essential community provider provisions, grants for development and expansion of services, grants to encourage providers to go to those areas most in need, enabling and supplemental services, and support for the development of telemedicine systems are but a few.

Another fundamental reason we must enact health care reform is to bring down the federal deficit. Unless our costs in Medicare and Medicaid are brought under control, balancing the budget will remain an almost impossible task. The Congressional Budget Office estimates that if we do not get our health care costs under control the debt will increase by 1.5 trillion dollars by the beginning of the next century due to health care costs alone. Our goal for universal coverage is not only humane, but is critical to a sound economy and federal fiscal responsibility.

In designing a universal health care system the Committee has taken an unprecedented approach to ensure that the cost of a new social program would remain fiscally responsible. In the Committee's first unanimous vote, we adopted an amendment offered by Senator Bingaman and Senator Kassebaum that requires that the National Health Board review the revenues and costs of health care reform, both at the outset and on an annual basis thereafter, to ensure that they match. If we are faced with a deficit, Congress will need to either act on the Board's recommendations for increasing revenues, or permit benefits to be decreased. In either event or some combination of the two, Congress and the public will face explicit and important choices about what we want from our health care system and what we are willing to pay for it.

A major message that has gotten lost in the debate over health care reform, which has largely focused on who should or shouldn't pay, is the need to fix a delivery system that is flawed. Emulating Medicare as recommended by colleagues in the House of Representatives, which has been a successful program for providing good

health care to our senior citizens but is extremely expensive and inefficient from a cost control perspective, is not the answer.

The federal government's answer to controlling the cost of Medicare and Medicaid has been to reduce the amount of money we will pay providers who take care of the poor and elderly. Not surprisingly, fewer and fewer providers are willing to treat individuals in these programs. In addition, providers try and make up the difference in lack of payment from government providers by charging private payors more for the same services. This cost-shifting has resulted in an increase of about twenty percent in the cost of premiums in the private market. Continuing to segregate people into insurance programs according to age, ability to pay, and high risk will only promote an already dysfunctional system. If we were to merge Medicare, Medicaid and the private sector into one seamless, universal system the costs for almost all individuals would be lower.

The Chairman's Mark, unlike the approach of some in the House, did not rely on the same expansion of the federal government's role. But it did, in my view, move further than necessary away from a market-based system.

Under the Chairman's Mark, states would assume most of the enrollment and administrative functions now carried out in the private market. For example, states would be required to establish and maintain health plan enrollment procedures; they would collect premiums from employers, individuals, and families on behalf of carriers and then make payments to these carriers; and they would monitor all employee "family status" changes (ie divorces, deaths, births) of employers.

This expansion of state duties, as well as the sheer number of people who would be serviced under this new regulatory structure, would greatly strain state budgets. In addition, it would greatly disrupt the way millions of Americans currently get health care in the marketplace—through their employers. Today, if an employee isn't enrolled properly in a health plan offered by the employer, the employer responds to the problem directly. If the state were to take on these functions, without the proper staffing and funding, how responsive could the government be to the consumer and would this be perceived as good government? It is not necessary to delegate these administrative functions to the states as additional regulatory powers in order to provide fair, equitable, and affordable health coverage to Americans. As a matter of fact, if we did this the administrative savings we are striving for in the provider arena would be replaced by administrative complexity for state governments and businesses alike.

With Senators Durenberger and Kassebaum, I offered an amendment that would have replaced most of the regulatory sections in Title I of the Chairman's Mark with a streamlined, market-based structure similar to the provisions found in both bi-partisan bills in the Senate, Breaux-Durenberger (S. 1579) and Chafee-Kerry (S. 1770).

The amendment's purpose was to restore the buying and selling of health care coverage to the private marketplace. Buyers, employers with 100 or more full-time employees, would be encouraged to continue to put a downward pressure on health care costs by re-

maining active negotiators with sellers in the marketplace: doctors, hospitals and health plans.

The amendment established a framework of national standards that allows locally-based health plans and local markets to deliver health care more efficiently to all Americans. The federal government will enact uniform, national standards for quality, accountability, outcomes data, and service requirements, to assure that locally-based health plans deliver quality health care. The establishment of bright-line federal rules enforced by the states would level the playing field between fully-insured health plans and the Employee Retirement Income Security Act (ERISA) self-insured plans. National uniform rules would enable the private marketplace to begin to function rationally rather than continue in its current dysfunctional mode of operation.

The amendment would authorize voluntary purchasing cooperatives. These are private, non-profit organizations that assume no risk or regulatory authority but must be certified by the state in order to operate. We provided for incentives for purchasing cooperatives to form in the marketplace but did not require a state to establish one for each region. The objective of these voluntary cooperatives would be to pool small employers (under 100 employees) and individuals into large groups so that they could have the same buying power that large employers enjoy today.

Unfortunately, the amendment as offered was defeated on a vote of 5-12. As a compromise, I agreed to sponsor an amendment offered by Senator Bingaman which made critical structural changes to the Mark. I think this amendment maintained the ultimate goal of moving the Mark in the direction of a market-based delivery system rather than one that is overly bureaucratic and regulatory.

The amendment offered by Senator Bingaman, myself and others accomplished three major objectives:

- (1) It established a framework of national standards that allows locally based health plans and local markets to deliver health care more efficiently, thereby increasing state flexibility in the choice of delivery system. For example, if a state thinks multiple voluntary competing cooperatives will be effective for getting the delivery system working or if a state thinks one negotiating cooperative in a region will do the job, both are options the state may choose. This is a specific area in which the federal government should not micro-manage.

- (2) It positioned the employer responsibility and choice continuum and the individual responsibility and choice continuum at the midpoint. What I mean by this is that although individuals do not have unlimited choice of plans in the marketplace—they will have a choice among at least three different plans. Employers who are required to contribute will not have the administrative burden of making payments to health plans all over the region.

- (3) Large employers have had a dynamic impact as purchasers in the marketplace in getting health care costs under control. By removing state governments as the intermediary between purchasers and sellers, we have been able to eliminate a needless role for State governments that would have required them not only to enroll all citizens but also collect premiums

from employers and pay health plans. Americans connected with the workforce can be assured that they will be able to continue to enroll for their health care coverage through their employer. The State's role should be as a back-up for those individuals not connected with the workforce or for individuals who are self-employed.

Even with the adoption of the Bingham amendment, I believe in some respects the bill reported from the committee is needlessly complex and regulatory and in need of further improvement.

For example, the rules and reporting requirements imposed on employers to ensure that two-worker families and part-time and seasonal workers are making proper payments or being appropriately subsidized are too cumbersome and costly. I think there is a better approach than the creation of the "dual worker factor" and the subsequent gyrations in the legislation that are needed to make it work.

An intricate accounting and reporting mechanism has been set up which requires employers to report to the state and federal government, on a monthly basis, all family changes made to an employer's employee masterfile. Even submitting these changes by electronic tapes will no doubt cost employers and the government money to administer and audit.

It is my understanding that the main purpose for developing this formula was to help alleviate the burden on big business which in essence is subsidizing small employers for the cost of workers health benefits. Today, many large businesses provide family coverage to workers. Therefore, small employers can defray their business expenses by not offering health insurance to workers who are covered by a spouse's plan. But in trying to reallocate costs away from big business, the Mark requires these same businesses be assessed one percent of payroll. For what? To help subsidize small businesses who cannot afford the employer mandate as structured. In addition, the Chairman's Mark subsidizes large employers whose cost for health care is greater than twelve percent of workers wages.

To summarize, in order to minimize the cost shift from small employers to large employer's payments for family coverage, the dual worker factor was created. In order to minimize the impact of the employer mandate on small business, we subsidize small low wage firms by assessing large employers one percent of payroll. In order to alleviate the burden on large businesses, we subsidize firms whose health care costs are greater than twelve percent of employees' wages. If the goal is to reduce health care costs and stop cost shifting let's do it. Let's not get caught up in another expensive cost shifting methodology and muddy up the water for true reductions in health care expenditures.

While most of the committee's work improved upon President Clinton's proposal, in some areas it did not. One significant change from the Clinton bill to the Chairman's Mark was a change in the remedies available in the benefit claims denial section of Subtitle C of Title V.

Under current law, the vast majority of Americans, roughly 90 percent, who receive health benefits from an employer are entitled to remedies under the ERISA. These remedies are limited to the

amount of the benefit in dispute. Ironically, at a time when there is some consensus that tort liability has a substantial impact on the practice of medicine, the committee-reported measure would convert what have been contract disputes into tort cases with unlimited damages and substantial transaction costs.

According to my understanding of the Clinton bill, the current ERISA remedies would remain in effect for all plans offered to employees who experience rate rather than community rate. Currently, damages available under ERISA for a denied claim in any employee benefit plan, whether fully insured or self-insured, are limited to payment of the claim. These are the same damages available under the FEHBP. Today these disputes are treated as contract disputes, not tort disputes. The damages available to virtually all private and federal employees and their dependents, probably close to 200 million people, are contractual damages, not the damages we associate with tort claims such as malpractice.

As passed, the committee bill would allow "any appropriate relief" to all claimants in the claims grievance procedures. The impact is that any state remedy, including pain and suffering and punitive damages, could be available to any claimant who wins in court. Instead of current law remedies, which I agree are too limited, this bill will say the sky is the limit. Instead of limited venue, this bill will permit forum shopping. And instead of promoting stability, uniformity and reduced costs, this bill will create uncertainty, wide disparities, and sharply increased costs. And while I support state flexibility in many areas, I think we do a disservice to the notion of a uniform and portable benefits package if we have fifty state court systems coming to different conclusions as to what is and is not included in the uniform benefits package.

Under the Labor bill, ERISA's limited remedies are null and void. As a result, costs to health plans and the federal government are apt to rise, and premiums and federal subsidies will necessarily do the same.

Rather than creating a system that is expeditious and fair for both the individual and the plan, the Labor bill encourages needless litigation. I agree that the current system is not fair to consumers, but most people just want to know why they didn't get a benefit they thought they deserved. People want a neutral third party to listen to their point of view and render an opinion. For example, a woman who wants a mammogram does not want months of arguing over the question. The question of whether you are high risk and entitled to an annual mammogram should be settled swiftly and with as little legal intervention as possible.

Rather than promoting early dispute resolution by requiring individuals to use a dispute resolution process prior to going to court, this bill allows individuals to go directly to court. This will open up the floodgates for costly litigation. The number of claims handled last year by just one of the largest insurance companies totaled 80 million. The dollar amount of these claims was \$15 billion. Under present law standards, only 300 of these cases proceeded to federal district court. The reason is because an overwhelming majority of claims disputes relate to small claim dollar amounts and are settled in the internal resolution process. The current system provides

an incentive for the parties to work out their differences rather than go into court.

As we strive for an integrated system of care we must look around at where we are today. Indeed, the majority did exactly this when fashioning and defending the proposed benefits package. There are a variety of ways people get health insurance today: Medicare (parts A & B); individual insurance policies; employer group policies (usually ERISA plans); and let's not forget FEHBP, just to name a few. As many ways as there are to get insurance that is how many different schemes there are for resolving benefit claims disputes as well as the remedies available for each. In the remedies area, the committee opted for the Cadillac.

In an effort to address these problems, Senator DODD and I offered an amendment that failed (8-9). Our proposal melded the various claims procedures and remedies currently under Medicare, FEHBP, and ERISA. We created an expedited process. Claims would be resolved quickly before there is a delay in treatment or payment. In addition, we establish a fast-track review process for urgent requests for treatment. This provides for claimants to get needed services prior to any harm occurring.

Currently, the damages available to individuals depend on the type of insurance they have and how they get that insurance. For example, under FEHBP, ERISA and Medicare, there are no punitive or extra-contractual damages available. Our amendment more than doubled the damages currently available to federal employees and private employees covered under ERISA by adding liquidated damages and lost wages to current remedies. It promotes the cost containment goals of health care reform by permitting health plans to set prices competitively based on predictable risks and liability.

Our amendment would have set up an administrative process for adjudicating claims, rather than requiring people to face the hired guns for the insurers in federal district court. Given the backlog in our courts, I don't think we need to add this discrete and very difficult set of problems to their workload, especially if our aim is to give people a quick resolution of their claims. I also think we should have people try to settle their differences before they become adversaries.

Our grievance procedure was modeled after the grievance procedure used by FEHBP—alternative dispute resolution and then court if necessary. All individuals would go to a state complaint office to file a grievance no matter what size employer they work for or where they purchased their insurance. Uniform federal procedures and remedies are established so that all claims disputes on the uniform benefits package will be handled similarly. It avoids the patchwork decisions created by state litigation.

It is important to note that the benefits debate has a direct bearing on this claims debate. No matter who decides the benefits, and no matter how prescriptive they may be, there will be hundreds of unanswered questions. These benefit coverage questions will come up on any number of contexts. Is the treatment experimental? Is it part of the statutory or regulatory package? The list goes on and on. And despite our best efforts, these questions will be dumped in the laps of the plans. In most cases, as today, the answer to these questions will be yes. But if we are really serious about controlling

health care costs, we want plans to be able to say "no" when appropriate without fear of costly litigation.

Under the language of this bill, we don't provide this assurance. If this language is not changed, plans will practice defensive claims approval just as doctors now practice defensive medicine. If the cost of saying "no" becomes too high, we can be sure it will never be uttered, and the costs of premiums will climb ever upwards.

The design of the benefits package is another area in which I have concerns about the bill. I echo the minority's view that the package is too specific and too expansive. Most importantly, by placing the power to design the benefits package in the hands of Congress, it politicizes one of the most crucial elements of our health care reform efforts.

I supported in Committee, and continue to favor, Senator Kassebaum's approach which establishes an independent commission to design one or more packages with specific guidelines from Congress. This approach would insulate the design process from political, rather than medical, decisionmaking. The benefits package not only represents the security that we are offering the American people, it is intimately tied to our ability to encourage efficiency in the delivery of services and to control costs. To design the package in Congress compromises our ability to achieve both of these objectives.

Lastly, I also concur with the minority views regarding the new early retiree health entitlement program. I am particularly troubled that the cost estimate of this new entitlement is grossly understated. According to a 1991 study by the Employee Benefit Research Institute (EBRI), only forty-three percent of full-time employees of medium and large private establishments had a promise of employer financed retiree health before age 65. Couple this with a General Accounting Office report that estimated the Final Accounting Standards Board FAS 106 liability for private employers in 1993 was \$412 billion. It doesn't seem to add up that this new program where the federal government pays eighty percent of the premium for individuals between the ages 55-64, with ten years of Social Security work history, would only cost the federal government \$11.6 billion over three years.

While I believe the estimated costs of the early retiree health entitlement are probably understated, I am more troubled by the fact that the Labor Committee is filing this report without the benefit of Congressional Budget Office (CBO) cost estimates. At each stage of the process, it seems we are told to expect an estimate at the next stage. While I understand the demands on CBO, I cannot contemplate considering a bill on the Senate floor for which an estimate does not exist.

I am committed to passing a broadly bi-partisan bill that will ensure that all Americans will have health care that can never be taken away if they get sick or lose their job. But if insurance becomes too costly because of unnecessary litigation or because we do not include the proper incentives to get our delivery system working efficiently, what have we really accomplished?

Universal coverage requires both accessibility and affordability. Step one is to pass legislation that has the right incentives in getting the delivery system operating efficiently so that costs are

under control. Step two is to create a universal, seamless system of private health coverage, integrating both Medicaid and Medicare, which will enable the federal government to reduce the deficit. We must pass legislation that embraces a partnership between the American people, American businesses of all sizes and our government. And we must resolve this year which year we want universal coverage, not whether universal coverage is required.

JAMES M. JEFFORDS.

MINORITY VIEWS

Responsible health care reform is a critical national priority, but the reform legislation reported by the Labor and Human Resources Committee June 9 is not an appropriate prescription for the problems we face.

Although it does differ in certain respects, the Labor Committee's reform bill is disappointingly similar to the proposal put forward last fall by the Clinton administration. Indeed, the committee bill includes the same heavy mandates, excessive government regulation, and unaffordable promises that have already turned the American people away from the President's prescription for reform.

We strongly oppose this legislation, as well as the accompanying committee report. We do so, however, as members who recognize a need for serious change in our health care system. Indeed, each of us has either sponsored or cosponsored comprehensive reform legislation. Clearly, the status quo cannot be sustained—which is why the health care system is changing itself, even in the absence of legislation.

We acknowledge the commitment and serious attention that went into the committee's markup deliberations. We are, however, deeply disappointed with the product. Committee debate and discussions were thoughtful, and we hope they served to clarify some of the fundamental issues involved in health care reform. The quality of the debate, however, did not translate into a quality piece of legislation. The committee views prepared by the majority convey an impression of bipartisan consensus on this bill that simply does not exist.

We are also deeply concerned that this legislation was marked up without benefit of any reliable estimates of its cost, either to the Federal Government or to the health care system. Despite strong requests from minority members of the committee, the sponsors of this legislation have yet to provide any serious analysis of its fiscal impact. As we will discuss in greater detail below, we believe this omission to be irresponsible, especially considering that this bill, if enacted, would represent the most substantial domestic policy initiative since the New Deal.

This legislation reflects the unfortunate fact that Congress and the administration have lost their sense of what the health care debate is really all about. What initially sparked the reform process several years ago was deep public concern about the cost of care. Today, the discussion has lost its roots in concern about costs—and, in fact, has seemed to take a direction where cost is no object.

The American public does seek a sense of security that health care will be available and affordable, and these concerns are real. The question is whether we are addressing these concerns or whether we are adding to them.

We must recognize that general public concern about health care is a fragile foundation indeed. What we fear we are doing is building a massive skyscraper on the shifting sands of an uncertain public consensus. We have done so without knowing the cost of the building or whether anyone either wants to or can afford to move in.

A variety of agendas—many of them contradictory—have come into play in the name of addressing the public's concerns. The failure in leadership has been the failure to establish the ground upon which true consensus lies and to define the task in terms of what realistically can be accomplished.

We fool ourselves, if we think Congress and the Federal Government, in one fell swoop, are going to be able to design and regulate every aspect of the system from specifying the exact number and types of vaccines covered for 3-year-olds to the prices that plans will charge for insurance premiums. The public expects government to "fix" health care, not to run it.

This is where the President went off track. He interpreted public concern about health care as a mandate for a government takeover of the system. This is a clear misreading of the situation.

The legislation reported by the Labor Committee makes the same mistakes. After sorting through some differences in semantics, we find that the basic core of the Clinton bill emerges unscathed. The Labor Committee bill is just as big, just as complex, just as reliant on government regulation, and just as restrictive of personal choices as the Clinton bill.

Unfortunately, the most troubling elements of this bill going into markup remained virtually intact in the final legislation as reported: These include:

1. Massive government regulation;
2. Heavy employer mandates;
3. An extensive and overly specific benefits package,
4. Rigid premium caps,
5. Questionable financing,
6. New opportunities for costly litigation, and

7. A small forest of costly new programs, particularly in the area of public health.

Our principal concerns on these central points are outlined below, as are additional observations about other important aspects of the legislation.

EXCESSIVE GOVERNMENT REGULATION

As laid before the committee, the chairman's mark clearly chose a highly regulatory, rather than market-based, model for structuring a reformed health care system.

The chairman's mark did make participation in health alliances voluntary—a departure from the President's proposal. In so doing, however, it did nothing to alleviate the presence of heavy, top-down controls in the system. Rather, what the chairman's mark did is simply MOVE the former regulatory functions of the alliances onto the state governments.

Even as amended during the markup process, the committee bill would still require the presence of state-chartered health alliances in every region of the country—as in the Clinton proposal. What

would be new, however, is that we would now face extraordinary new regulatory powers by state and federal bureaucrats.

Businesses, for example, would be required to report to government agencies any changes in the "family status" of their employees (i.e., divorces, deaths, births). State governments and Federal agencies, in turn, would become responsible for new functions such as operating mechanisms for insurance plan enrollment, enforcing and administering premium caps on insurance plans, administering a new and complex system of premium discounts and subsidies to businesses and individuals, reviewing and approving marketing materials used by insurers, and implementing a mandatory reinsurance system.

Moreover, only the largest of businesses would be permitted to negotiate on behalf of their employees for cost-effective care from health plans, something millions of businesses do today. Instead, most employers would see their role reduced to that of check-writer, paying a standard amount no matter which health plan is chosen.

In total, this bill imposes upon state governments over two dozen new regulatory authorities. It also provides for the creation of 20 new Federal agencies or commissions, and establishes a central National Health Board whose specific regulatory functions number well over 200 (and whose decisions would frequently be exempt from administrative or judicial appeal).

During committee consideration of the principal structural subtitles of title I of the bill, a number of amendments were offered to address some of these regulatory burdens, including two comprehensive substitute proposals.

One of these, sponsored by Senators Jeffords, Durenberger, and Kassebaum, was defeated on a vote of 5 to 12. Important changes called for in this proposal included:

The principal administrative provisions of the chairman's mark (subtitles C, D, E, and F of title I) would be eliminated and replaced with a streamlined, market-oriented structure based substantially on S. 1770, the Health Equity and Access Reform Today Act, introduced by Senator John Chafee.

States would not be required to establish purchasing cooperatives.

Cooperatives would be private and voluntary, but would have to be certified as meeting basic requirements.

Health plans would have to comply with modified community rating, guaranteed issue, and other reforms to assure fairness and equity in the insurance marketplace.

Employers with more than 100 employees would have the option of negotiating competitive rates with health plans.

There would be no new state "clearinghouse" for centralized processing of insurance premiums and payment, nor would States be given the responsibility of setting provider rates for fee-for-service plans.

A subsequent amendment, offered by Senator Bingaman and Senator Jeffords, incorporated some of the provisions of the earlier amendment but ultimately retained a much greater share of government regulation in the marketplace. This amendment passed by a vote of 9 to 8.

Key areas in which the Bingaman amendment departed from the Jeffords/Durenberger/Kassebaum amendment included:

Only businesses larger than 500 would be permitted to negotiate competitive rates with health plans.

Large businesses (above 500) that chose to exercise this option would be subject to a payroll tax, effectively forcing them to "play AND pay."

States would be mandated to establish or operate purchasing cooperatives, although these would be voluntary.

There is a difference between setting up a structure that allows the system to heal itself and one which takes control of that system. There is a difference between offering businesses the flexibility to pool themselves together in voluntary purchasing groups and demanding that they do so through government-established alliance structures.

Relying on governmental regulatory structures, rather than market forces, as the framework for delivery of health services will bog us down in mounds of paperwork and a dizzying array of lines and boxes on organizational charts.

HEAVY MANDATES

A fundamental component of the committee's bill is the mandate that employers pay 80 percent of the cost of their employee's health care, as well as a mandate on individuals to purchase coverage. We consider this approach to be fundamentally flawed.

Of particular concern is the heavy toll employer mandates would take on American jobs, wages, and economic performance. Whichever specific estimate one chooses to use, the bottom line is that jobs will be lost as a result of an employer mandate. Analysts may differ on the specific number, but they agree that workers with the lowest wages and in the poorest families have the highest probability of losing their jobs. The average wage loss per worker from an 80 percent employer mandate is estimated to be about \$1,200.

In a recent report (March 1994), the Congressional Budget Office (CBO) agreed that "the cost of 'employer-provided' health insurance is ultimately passed on to workers in the form of lower wages and reductions in fringe benefits other than health insurance."

Some have attempted to portray the Labor Committee's version of the employer mandate as a lessening of the mandate burden on businesses, especially small firms. The reality, however, is that the committee's mandate would actually result in a heavier burden on many businesses than would President Clinton's proposal. Also, contrary to suggestions in the majority report, no firm—however small—would be fully "exempt" from a mandate to pay.

The Clinton plan would have required all businesses to provide and pay for up to 80 percent of the cost of a comprehensive benefits package, up to a specified cap on employer liability. The chairman's mark retained this mandate, but did provide some relief for very small "mom-and-pop" businesses.

It is important to note, however, that only some small firms would qualify for this relief—and that this relief would not be complete. To qualify, small businesses would have to have an average annual wage of less than \$24,000. These small businesses would also be subject to a 1 to 2 percent payroll tax—and their employees

would still be mandated to purchase the comprehensive benefits package.

During the markup, the committee adopted an amendment by Senator Bingaman to expand from five to ten employees the threshold for small businesses eligible to qualify for this relief. Firms with 1 to 5 employees would pay a 1 percent payroll tax, and those with 6 to 10 employees would pay a 2 percent payroll tax. Also, as in the chairman's original proposal, only small businesses with average annual wages of under \$24,000 would qualify.

Even as revised by the Bingaman amendment, the employer mandate in the committee bill would place an even heavier financial liability on many midsized businesses than would the Clinton plan. Whereas the caps on employer liability in the Clinton plan range from 3.5 percent to a maximum of 7.9 percent of payroll (depending on firm size and average annual wages per employee), the Labor Committee bill sets these caps much higher—ranging from 4.2 percent of average annual wages per employee to an exposure of as much as 12 percent of average annual wages.

At a maximum of 12 percent of average annual wages, these caps on firm liability for health care costs are noticeably greater than the average current health benefit liability of most businesses today. For example, employers with fewer than 100 employees currently spend on average just 6.9 percent of payroll on health care. Meanwhile, employers of 100 to 499 employees spend on average 8 percent of payroll, and employers with more than 500 employees spend an average of 9.8 percent of payroll on health benefits.

The employer mandate provisions in the committee bill would also create significant financial disincentives for small employers to increase the number of workers they employ, or to raise wages. This is of particular concern in view of the fact that the small business sector is currently the primary source of job growth in our economy.

Specifically, the mandate provisions in the committee bill create a significant "cliff effect," which, if enacted, would dramatically penalize small firms for hiring even one or two additional workers. For example, a firm with five employees would double its payroll tax liability if it decided to hire a sixth. Similarly, an employer with 10 workers would, if it hired an eleventh worker, trigger a requirement that it pay 80 percent of the cost of insurance for all employees, thereby increasing its financial liability from 2 percent of payroll to anywhere from 4.2 to 12 percent of its average annual wages per employee. Conversely, businesses with 6 or 11 workers would substantially reduce their liability for insurance costs or payroll taxes by firing just one employee.

Although the committee bill—like the President's plan—includes subsidies aimed at easing some of the burden of mandates, businesses have every right to question how reliable these "protections" will prove to be over time. They worry that the benefits already mandated and the additional benefits Congress may mandate in the future will be so rich that these protections will eventually erode or disappear.

Already, the evidence is substantial that the cost of sustaining employer subsidies at the level promised in the Clinton bill and the Labor Committee bill will be a great deal more than initially antici-

pated. Specifically, the Congressional Budget Office (CBO) has estimated that the true cost of the employer subsidies under the administration's plan would be at least \$25 billion higher than the administration had estimated. Similarly, the CBO projected that the premium required to cover the cost of the Clinton benefits package would be 15 percent higher than the administration's estimates.

Finally, extensive, complex, and costly reporting and record-keeping requirements are another alarming aspect of the mandate provisions in the Labor Committee bill. The bill imposes nearly 30 mandate-related paperwork and regulatory requirements on businesses. Each month, for example, employers must apprise the state of any newly hired and fired employees; wage increases or cuts; workers changing from part- to full- or full- to part-time status; and changes in a worker's family status due to marriage, divorce, and birth of a child, or other events.

Furthermore, each year, every employer must calculate and report to the State the number of months of full-time equivalent employment for each employee; the amount deducted from wages for the family share of the premium; the number of full-time employees for each class of enrollment broken down by month; the amount of covered wages for each employee; any shortfall in employer payments; and any additional information the Department of Labor may decide to require.

AN EXTENSIVE AND OVERLY SPECIFIC BENEFITS PACKAGE

The committee bill all but writes an entire benefits package into statute. In our view, this level of detail is excessive for legislative language, and it invites the addition of any items not already specified. More generally, this approach lays the groundwork for assuring that we will ultimately be unable to say "no" to anyone or anything. Some of us also seriously question whether a standard benefits package is needed at all.

The Labor Committee bill significantly expands upon the President's proposal in both the scope and the specificity of services included in the standard benefits package. Particular areas where the committee bill goes well beyond the President's plan include mental health, substance abuse, children's services, hearing aids, women's health care, and services for the disabled.

In an attempt to help finance the cost of these expanded benefits, the committee bill proposes to make changes in the cost-sharing schedule. We are concerned, however, that this cost sharing structure raises serious concerns of equity and practicality. For example, standard insurance practice usually requires a family maximum out-of-pocket limit that is about two-to-three times that of an individual. Under the committee bill, however, maximum out-of-pocket limits would be \$2,500 for an individual and \$3,000 for a family. The net effect of this change is that single people will be indirectly but significantly subsidizing the cost of insurance for families,

The minority offered a number of alternative amendments during the markup. One of these was a Kassebaum amendment to take benefit design out of the hands of Congress and, instead, create a politically buffered, independent commission to set the package.

Under the Kassebaum amendment, an independent commission would have been directed to develop three benefit packages using the same categories of benefits required for the Federal Employee Health Benefit Program (FEHBP), with the addition of long-term care and preventive services. The amendment would also have required that the actuarial value of each of these packages be no greater than that of an average plan currently offered by the FEHBP. According to Congressional Research Service estimates, the actuarial value of the current average FEHBP plan is roughly 10 percent lower than that of the benefits package proposed in the President's plan.

Another amendment, offered by Senator Coats, would have removed the bill's standard benefits package in its entirety. The intent of the amendment's sponsor was to preserve choices for consumers and businesses among a variety of health care plans and to avoid the uniformity that would be required by a nationally standardized package. This amendment would have allowed persons to choose for themselves the mix of benefits they believed best suited their own needs and the needs of their families. This amendment was supported by all but one of the minority members, some of whom voted for it not out of opposition to a uniform package as such, but rather because of concerns about the richness and specificity of the particular package in the chairman's bill.

We are also opposed to the treatment of abortion in the benefits package provisions in the committee's bill. The basic benefits package as delineated in the committee legislation includes abortion as part of the full range of reproductive health care services.

In view of the fact that the committee bill would put taxpayers in the position of subsidizing the cost of health care for many Americans, we believe it is inappropriate to include the sensitive service of abortion as a required benefit. Moreover, we believe that the Committee bill would unreasonably restrict state laws restricting the performance of abortion and insurance coverage of abortion services.

Two amendments were offered during markup which would have significantly restricted the inclusion of abortion in the benefits package, but neither was adopted. Specifically, an amendment offered by Senator Coats would have restricted the coverage of abortion except when the pregnancy was the result of rape or incest, or if the life of the mother was endangered. (Similar restrictions apply to the use of current federal funds to pay for abortions.)

Another amendment, offered by Senator Gregg, would have ensured that nothing in the health care reform legislation could be construed to conflict with any constitutional State law restricting the performance of abortion within the State. The purpose of this amendment was to protect State laws regarding parental notification and consent, informed consent, post-viability abortions, and other State abortion restrictions.

During consideration of the benefits package, the committee also adopted an amendment offered by Senator Bingaman to require reductions in the benefits package in the event that costs prove greater than anticipated. Although members of the minority hold varying views on the appropriateness of a uniform benefits package and its design, we agree that the scope of benefits offered under

health reform legislation must be firmly linked to the cost of such benefits.

RIGID PREMIUM CAPS

The committee bill includes a heavy-handed and harsh method for controlling health care costs through insurance premium caps. Specifically, this legislation largely retains the premium caps included in the Clinton plan. It would force reduction in the growth of insurance premiums down to the level of the Consumer Price Index (CPI) over a 3-year period beginning in 1996.

Enforcement of the caps would be performed by the States according to the federally set limits. This differs from the President's bill, in which the health alliances were primarily responsible for enforcing and administering the caps.

In our view, these caps threaten to disrupt, if not destroy, the effective working of the health care marketplace. Although portrayed by advocates as a "backstop" to market forces, their true effect will be to wring unsustainably large sums from the system in a short period of time.

Other countries, including the government-managed systems for Canada and Western Europe, have not even come close to forcing cost growth down to the level of general inflation—as the committee's bill proposes to do. For example, Germany's average annual health care cost growth level from 1980–91 was inflation plus 2.4 percent. Canada's was inflation plus 2.8 percent—and even the single-payer British system has succeeded only in holding health care cost growth to inflation plus 2.4 percent.

Even Prospective Payment and Assessment Commission Chairman Dr. Stuart Altman conceded in congressional testimony last fall that a CPI-plus-zero target like the one in this bill "would create a tighter spending control system than that of any other nation."

Forcing costs down unreasonably fast will pull billions of premium dollars out of the system, force even good faith insurers and providers out of business, and ultimately lead to pronounced health care rationing. This will be especially true in the less financially desirable underserved regions of the country.

We are also very troubled that premium caps have become a means to make projected subsidy and other costs appear to be much lower than they actually are. It is alarming to consider the budget implications if we discover later that cost projections related to the premium cap turn out to be wrong. One recent analysis conducted by Peat Marwick concludes that the caps in the President's bill would be at best 50 percent effective. If Peat Marwick is right, the result will be a \$101 billion shortfall in financing of the President's bill in the year 2003.

Committee debate on the premium cap issue also highlighted the fact that the caps in the Labor Committee bill are calculated such that they would unfairly reward traditionally high-cost states at the expense of traditionally low-cost regions.

Because the committee's bill bases its premium caps on historical spending levels, relatively low-cost states like Minnesota or West Virginia would be locked into much tighter spending controls than high-cost states like Massachusetts or California.

We believe this is unfair, particularly considering that premium caps locking in regional disparities in premium amounts would have a direct impact on the level of federal subsidy a state would receive under the bill. In fact, under this legislation, taxpayers in low-cost states would provide escalating subsidies to residents in high-cost states.

The President's plan called for a committee to evaluate and recommend ways to lessen such regional disparities by the year 2002. The Labor Committee bill creates a similar committee, but extends its deadline to the year 2006.

QUESTIONABLE FINANCING

We are deeply troubled that this sweeping proposal, with its generous benefits and extensive new entitlements, was drafted, debated, and voted out of committee without any thorough or independent assessment of its cost.

By any measure, the committee's health care reform plan would, if enacted, represent an overhaul of one-seventh of the U.S. economy, as well as the most substantial domestic policy initiative since the New Deal. In our view, it is fundamentally irresponsible to advance legislation of this magnitude without having any accurate idea of what it will cost or how it will be financed.

On the first day of markup deliberation, Senator Coats offered an amendment which would have required a Congressional Budget Office (CBO) scoring of the bill before the legislation was voted out of Committee. We regret that this amendment was defeated, on a party-line vote of 10 to 7.

We also object strenuously to the fact that the official committee report for this bill has now been filed without the required fiscal analysis by CBO. This runs directly counter both to standard Senate practice and to the express assurances of the chairman that the bill would not be reported to the full Senate until cost estimates were available.

The importance of having accurate cost estimates is underscored by the fact that such estimates are expressly called for in both in the Senate Rules and in the Congressional Budget Act. Specifically, rule XXVI, paragraph 11 of the Senate rules, and section 308(a) of the Budget Act clearly state that all committee reports on legislation shall be accompanied by a cost estimate and analysis of the bill's fiscal impact. Moreover, subsections 308(a)(1)(E) and 308(a)(1)(D) of the Budget Act go on to specify that an analysis from CBO shall be included in such a report.

We also note that the chairman, in his remarks during the markup, clearly stated that, "We are going to have CBO figures, obviously, before we report" the legislation.

We are dismayed that the Majority has attempted to evade the rules by citing questionable technicalities, particularly considering this issue's magnitude, complexity, and importance to the Nation.

During the committee's markup process, the only available figures relating to cost and financing of this plan were very general estimates prepared by the majority staff. As correspondence from CBO, the Office of Management and Budget (OMB), and the Congressional Research Service (CRS) has confirmed, these staff esti-

mates did not represent the findings or conclusions of any of these bodies.

The chairman has claimed not only that his legislation would be "budget neutral," but that it would also "eliminate" the \$74 billion increase in the budget deficit which CBO projected would occur under the President's plan. No detailed analysis substantiating either of these claims was ever presented to the committee.

The Majority staff's cost estimates draw heavily on the presumption that a scoring of the committee bill ought to correspond closely to the CBO scoring of the President's proposal prepared earlier this year.

While it is true that the committee legislation does closely resemble the President's proposal in most respects, it departs from the administration plan in a number of areas that are central to the estimating of the plan's fiscal impact.

One of the most important of these differences is the fact that the committee bill would no longer rely on health alliances to manage or enforce the premium caps, as would the President's plan. Instead, the committee's proposal would diffuse this authority to various State and Federal agencies. CBO's report on the President's proposal concluded that the scoring of the effectiveness of the premium caps in the President's bill was predicated on the presence of the alliances to act as centralized administrators of the controls. Although we in no way endorse either the creation of health alliances or the bill's premium caps, we are very concerned that CBO's analysis of the committee bill—when and if it occurs—may conclude that the changes made in the committee's bill will result in considerably higher cost estimates than those for the President's proposal.

This legislation also makes fairly substantial changes from the President's proposal in how risks are pooled, how subsidies are structured, and how the insurance system is administered. These and other features of the committee bill make it impossible, absent thorough analysis by CBO and other agencies, to know what the actual costs will be.

Even had we waited for official cost projections—which this committee has chosen not to do—there would be serious reason to worry about their long-term accuracy. Indeed, the Federal Government's track record in projecting the costs of new social programs—especially entitlements—does not inspire confidence.

For example, when Medicare was enacted in 1965, it was projected that in 1990, the part A hospital program would cost \$9 billion a year. The actual expenditure for part A in 1990 turned out to be \$67 billion—7½ times the original estimate.

To try to pay for the cost of its new programs, the committee bill would levy several heavy new taxes and assessments. These include the mandate on employers to pay up to 12 percent of their average annual wages, the requirement on individuals to spend up to 3.9 percent of income on insurance, a 2 percent payroll tax on employers who do not participate in the program, a 1 to 2 percent corporate payroll assessment on large employers, a 1 percent surtax on all premiums, and a \$1.50 per pack increase in the cigarette tax.

In addition, the committee bill includes a section expressing the "sense of the committee" that existing Federal entitlement programs—over which this committee does not have jurisdiction—be cut to the levels proposed in the administration's plan. According to CBO, the administration's proposal would reduce Medicare spending by \$218 billion over the next decade, and Medicaid spending by \$446 billion over the same period. The committee did not vote to make these cuts, even though they are essential to financing the generous promises the committee bill makes. Indeed, we question whether a majority of this committee would have voted for this large level of Medicare and Medicaid cuts had the provision actually been binding, rather than merely "sense-of-the-committee."

NEW OPPORTUNITIES FOR COSTLY LITIGATION

One of the most distinctively troubling features of the Labor Committee's version of health care reform legislation is the extraordinary degree to which it opens up endless new opportunities for expensive litigation.

We agree that fair recourse and remedies can and should be made available. However, we are very troubled that virtually every new requirement imposed by this bill comes with accompanying legal rights of action and administratively complex structures for grievance and appeal.

Claims review and consumer protection

We believe that the claims review and consumer protection provisions in title V of this bill are severely flawed. Under the committee bill, claimants elect whether to sue in State court with traditional State court remedies, including unlimited compensatory and punitive damages, or to sue under an administrative procedure appealable to federal appellate court with remedies similar to those available in state court.

These unlimited damage remedies will increase the cost of health care for all of us and will diminish our ability to make health care accessible. These are precisely the type of jury awards that have caused a litigation explosion over the past decade in medical malpractice cases.

During the committee markup, Senator Jeffords and Senator Dodd offered an amendment providing a fair administrative review process with remedies, including the dollar amount of the benefits due under the plan, attorneys' fees, and liquidated damages (not to exceed the dollar amount of the benefits due) in the case of willful wrongdoing. We believe this approach offers a reasonable health care claims procedure and regret that it was not adopted.

Medical malpractice

Although the committee made progress on improving the medical malpractice provisions in the original chairman's mark, the bill still falls short of true malpractice liability reform.

Through the efforts of Senator Hatch, significant improvements were made with respect to provisions regarding demonstration grants and alternative dispute resolution. Also noteworthy was the adoption by the committee on an amendment to cap attorney fees below the 33⅓ percent contingency fee cap set forth in the original

bill. This vote represents the first time that the committee has recognized the need to curb excessive attorney contingency fees, which can take from one-third to one-half of the damage awards intended for malpractice victims.

We are also pleased that the committee adopted an amendment offered by Senator Coats aimed at helping protect tough State damage award caps from preemption by weaker Federal standards.

Nevertheless, the committee failed to adopt proposed amendments limiting excessive damage awards. Without meaningful caps on awards for noneconomic and punitive damages, spiraling litigation and "defensive medicine" costs will continue to drain limited resources from our health care system.

Anti-discrimination provisions

The committee bill significantly expands the categories of protected groups under civil rights law and provides broad new remedies for violations of the anti-discrimination provisions. Seeking to strike this unwarranted expansion of law, Senator Kassebaum offered an amendment during the markup which was defeated on a vote of 11 to 6.

The committee bill prohibits health plans, employers, large group sponsors (self-insured plans), States, the National Health Board, or any other covered entity from discriminating, limiting, or denying access to health care services on the basis of race, sex, national origin, age, disability, language, income, sexual orientation, health status, or anticipated need for health services. Neither language, income, sexual orientation, health status, nor anticipated need for health care services has traditionally been recognized as a protected category under civil rights law.

Health care legislation is not the place to expand the categories of protected groups recognized by Federal law. The potential consequences simply have not been considered. For instance, since the anti-discrimination provision covers employers, and the bill requires employers to provide health coverage to employees, any hiring or firing decision that even inadvertently causes a loss of health care access could open the employer to liability. For example, a manufacturer who refuses to hire an active drug addict could be guilty of discrimination based upon the applicant's "health status" and therefore could be subject to liability.

Perhaps more importantly, the anti-discrimination provision in this bill would make every adverse medical decision that potentially limits a patient's access to health care the possible subject of a civil rights lawsuit. If a health plan rejects a Native American's heart transplant due to lack of medical necessity, the patient could bring a disparate impact suit because—from a statistical viewpoint—Native Americans had not had as many heart transplants as other demographic groups.

In addition, unlike title VII of the Civil Rights Act (as amended in 1991), which provides for limited damage awards, the Labor Committee's health reform bill would provide for unlimited compensatory and punitive damages.

Moreover, the anti-discrimination provision is redundant because the committee bill already contains numerous safeguards to assure universal health care access. For example, under the bill, states

may not subdivide cities to segregate vulnerable populations and must ensure a choice of community-rated health plans. Health plans must distribute marketing materials to the entire service area, must accept for enrollment every eligible individual, and may not restrict coverage for any reason, including nonpayment of premiums.

PUBLIC HEALTH PROVISIONS

Health care reform offers us the opportunity and the challenge to improve the Nation's public health infrastructure, strengthen the health care delivery system in rural and inner-city areas, reform Federal support for medical education to achieve a better balance between primary care and specialist physicians, and consolidate and streamline the current plethora of categorical public health programs.

Sadly, we believe the committee's legislation misses this opportunity. Title III of the bill—the portion devoted to public health and related programs—was improved somewhat during the markup process. By and large, however, title III simply creates a number of new, costly, and excessively bureaucratic programs.

As more individuals and families obtain coverage through health care reform, many public health programs currently providing direct services to the uninsured and underinsured will no longer be needed or should be reformed to reflect core public health functions (rather than service delivery). The committee bill, however, neither eliminates nor reforms any current programs.

Core functions of public health

Instead of consolidating and reforming the current 19 different federal funding programs to state and local public health departments, the committee bill leaves all of these in place and creates three NEW categorical programs at the Centers for Disease Control and Prevention (CDC). These are: (1) a program expanding support for the core functions of public health, (2) a program for health prevention initiatives, and (3) a new comprehensive school health education program.

By core functions of public health, we mean those services performed by public health officers that are not directly related to providing health care treatment to patients. These functions include such work as monitoring disease outbreaks, organizing immunization drives, and conducting public awareness efforts.

Responding to an amendment by Senator Kassebaum, the committee agreed to establish a process under which various existing CDC categorical programs would eventually be consolidated into a single block grant for core functions of public health. We believe this is a step in the right direction, although an explicit consolidation of programs would have been preferable. The principal advantage of moving away from scattered categorical programs and toward a block grant approach is that it would give States greater flexibility to target funds to their own unique public health needs and priorities. Such an approach would also have eliminated much duplicative and costly administrative bureaucracy.

School health education

During the markup, the committee responded to Minority concerns about the creation of a new and duplicative school health education program by agreeing that an interagency task force would consider consolidation of existing programs in this area.

These changes represent an improvement over the original chairman's mark, but we do question the need for creating a new program where existing authorities already exist. Our preferred approach would have been the consolidation and refocusing of current programs, rather than the authorization of yet another program and attendant new bureaucracy.

School health clinics

The School Health Clinics provisions of the bill as reported are a significant improvement over the chairman's mark. Specifically, the role of local communities in the operation of school-based clinics would be strengthened.

Also, the funding authorizations in the chairman's mark were adjusted to reflect more reasonable assumptions about program growth and expansion. Funds for planning grants were limited to one year, and the use of funds for construction was prohibited.

Provisions in the chairman's mark requiring specific services to be provided in school-based or school-linked clinics were eliminated. Instead, local grantees will be given greater flexibility to design services that reflect the specific needs and available resources of their own communities. Further, a provision was adopted to ensure that clinics will adhere to State laws and regulations regarding the provision of medical services to minors.

Medical education

Addressing our Nation's undersupply of primary care physicians is vital to reducing health care costs and to expanding access to care.

The committee bill correctly diagnoses this problem, but arrives at the wrong prescription for solving it. Specifically, the bill proposes to have the Federal Government set training targets for each of 82 medical specialties and then determine which residencies in each area of the nation should be funded to meet these targets. We believe that this degree of control would be wasteful and unnecessary.

We regret that the committee chose not to consider several less prescriptive options in this area, such as those put forward by the Council on Graduate Medical Education (COGME) and by the Pew Health Professions Commission.

For example, a preferable approach would have been to use Federal funding incentives to promote the development of consortia linking medical schools with residency programs and other training sites. Such consortia would be given goals for the production of greater numbers of primary care providers, but decisions on how to reach these goals would be in the hands of local educators and health professionals—not a government agency.

The committee bill would also establish an all-payer fund for residency training through a 1.5 percent premium tax. While we acknowledge the need for stable funding for medical education, we

believe voluntary measures short of a required all-payer mechanism have yet to be fully explored. Furthermore, we believe that the necessary amount for an all-payer assessment—should one be established—needs further study.

An amendment offered by Senator Kassebaum to develop several of these alternative approaches was rejected.

The health care work force provisions in the committee bill would also establish a new job training program for health care workers within the Department of Labor. This new program duplicates existing efforts by other Federal agencies to assist health care workers who need to update their skills or be retrained for different employment. At a time when the administration is proposing to consolidate existing job training programs for displaced workers, we question the need for this new initiative.

Health services for medically underserved populations

The committee bill would create four new categorical grant programs aimed at addressing the need of medically underserved populations: (1) grants for the development and operation of community health plans and provider networks; (2) grants for the capital costs of developing community health plans and for renovating or expanding existing facilities; (3) grants for enabling and supplemental services, such as transportation and outreach; and (4) grants for telecommunications projects to link providers with medical centers and teaching facilities.

We agree that the key to ensuring access to care in medically underserved rural and inner-city areas is the development of strong, community-based provider networks and health plans. Such networks and plans will facilitate the development of a continuum of health care services, rather than the fragmentation of services typical under the current system.

Network development in underserved areas would also help promote the restructuring and consolidation of underutilized facilities and could help reduce or eliminate duplicative services. Communities with organized systems of care are also likely to be better able to attract and retain physicians and other health professionals.

However, the lack of any provisions in the bill to consolidate existing programs and to merge them with these new programs is likely to undermine—not stimulate—the creation of useful systems of care in rural areas.

For example, the purposes of the new grant programs overlap considerably with those of existing programs, such as the Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) program, the Rural Health Outreach Grant program, and the Rural Health Transition Grant program.

Finally, we believe that block grants to the States—rather than categorical grants to providers and facilities—would be a better approach to promoting the development of coordinated systems of care in rural and inner-city areas. A state-based block grant approach would also better assure that Federal funds flow effectively to those areas with the most severe problems—rather than to those institutions most knowledgeable about applying for Federal grants.

Title III of the committee bill also authorizes the Department of Labor to develop injury prevention programs, despite the fact that the Occupational Safety and Health Act of 1970 already authorizes the Labor Department to develop programs to prevent "unsafe and unhealthy working conditions in employment."

Moreover, the committee bill creates a new National Advisory Board for Occupational Injury and Illness Prevention to provide oversight and direction on workplace safety issues to the Departments of Labor and health and Human Services. It does this despite the fact that the current OSH Act has already established a National Advisory Committee on Occupational Safety and Health to oversee workplace safety programs.

ADDITIONAL AREAS OF CONCERN

Early retiree health care entitlement

Under the committee bill, the Federal Government—and by extension, taxpayers—would be responsible for paying 80 percent of the cost of the health coverage for all early retirees aged 55 to 64. The remaining 20 percent would be paid either by the retiree's former employer or by the retiree himself. This new entitlement would cost an estimated \$11.6 billion over fiscal years 1998–2000. Under the President's plan, a temporary recapture assessment on savings that employers would realize from the early retiree provisions would raise \$11.4 billion from employers during the same period, but would then expire.

Due to committee jurisdiction, the committee bill does not include the temporary recapture assessment. Instead, it is merely referenced in "sense of the committee" language that assumes the final version of health care reform will include certain financing sources outside of the Labor Committee's jurisdiction.

In our view, this costly new entitlement moves retirement policy in the wrong direction, particularly given the rapid aging of our population. We also believe it is unnecessary because it largely duplicates other assistance for nonworking persons provided elsewhere in the bill. Finally, we question the fairness of giving a special new entitlement to one category of nonworkers at the expense of other nonworkers.

We are sensitive to the special vulnerability of older retirees to the gaps in our current, employment-based health care system. Older workers, with their higher average wages and higher health care costs, are at greater risk of losing their jobs (and thus their health insurance) when businesses downsize, restructure, or convert. They are also likely to experience greater difficulty in finding new jobs with health care coverage or in obtaining health care coverage on their own.

These are clearly real problems, but creating a special early retiree health care entitlement is not the answer.

Instead of protecting older workers, this new entitlement would actually be a powerful incentive for employers to get rid of employees nearing retirement age. Specifically, the Congressional Budget Office has estimated that as many as 600,000 older workers would

either be enticed or forced into early retirement as a result of this provision.

Given the aging of our population and the declining ratio of workers to retirees, Federal policy should be encouraging individuals to remain in the work force, not to retire early. This provision runs counter to actions taken by Congress over the past decade aimed at encouraging persons to work beyond age 65, including raising the retirement age and easing the Social Security "earnings test."

We are also concerned that this entitlement would give one group of nonworkers—early retirees—preferential treatment based solely on age, not need. Under this bill, other nonworkers (i.e., unemployed younger people) would qualify for subsidized health insurance only if they are of modest means. For early retirees, however, the new entitlement would be fully available to anyone earning less than \$90,000 a year (or \$150,000 for a couple).

It is also important to point out that the insurance market reform provisions included elsewhere in this legislation (and in many other health care reform proposals) would largely alleviate the special health coverage problems older workers sometimes face when they try to buy individual policies after they retire.

Finally, we note with concern that the committee bill includes provisions which would effectively delay or deny Medicare benefits to persons over the age of 65 who choose to continue working. An amendment offered by Senator Gregg to correct this problem was rejected.

Long-term care

We understand that the lack of coverage for long-term home and nursing home care is a growing problem for many severely disabled individuals and their families. However, we do not believe the committee bill offers an appropriate solution.

The committee bill would establish a new entitlement program for long-term home- and community-based care. Unfortunately, this program would do little to coordinate or consolidate existing federal and state programs currently providing such services, such as Medicaid, the Older Americans Act, the Maternal and Child Health Block Grant, the veteran's health system, the Social Services Block Grant, and numerous other programs for the mentally ill and developmentally disabled.

Second, we believe this program holds out false hope to the severely disabled. Our fear is that although the promises in it are generous, it is not at all clear that available resources will be adequate to the demand.

Under this program, participating states would be required to provide all eligible individuals with an individual assessment and a plan of care, which could include a very wide range of medical and non-medical services. These requirements are mandated, regardless of any awareness of whether or not the states will actually have sufficient funds or capacity to deliver on them.

This uncertainty is compounded by the fact that it is extremely difficult to predict accurately how many individuals and families will qualify for and seek assistance under the program, particularly persons whose care is now being provided by family and friends.

Although the new home- and community-based care program in this bill is a "capped" entitlement, if the capped funding proves to be inadequate, there will be enormous pressure on the states and the Federal Government to spend more.

Third, 60 percent of the new program dollars under this program would be directed to individuals with incomes in excess of 200 percent of poverty. In our view, the principal emphasis of assistance should be on persons truly in need.

The committee bill would also create a new and separate long-term care insurance program under the Public Health Service Act. We believe that this program would put the Federal Government in direct and unequal competition with the private sector and that it would put future taxpayers at risk for potentially enormous unfunded liabilities.

Under this program, individuals at ages 35, 45, 55, and 65 would be eligible to purchase one of three levels of nursing home coverage and an equal level of asset protection. The only persons ineligible to buy the coverage would be those already in hospitals or nursing homes, and they would be eligible after a period of time following their discharge.

Supposedly, individual premiums would be set at levels appropriate to finance the program. However, given the strong risk of adverse selection and the nonforfeiture provisions in the program, it seems to us very likely that the Federal Government would, over time, be forced to assume an ever-greater share of premium costs and would face a growing liability for benefits.

Workers' compensation

We believe it is a mistake to expand the scope of health care reform to include State-run workers' compensation programs. In our view, reform efforts should be left to the States, where there has been recent progress in controlling costs and curbing abuses.

During markup, Senator Thurmond moved to strike the title X workers' compensation provisions in their entirety from the Committee bill. This amendment was defeated 10 to 7.

Subsequently, Senator Kennedy offered a substitute amendment to title X, which was adopted. We believe this substitute continues to raise serious concerns regarding the Federal role in State workers' compensation programs. In particular, health plans and providers would be required to comply not only with all legal duties and requirements under State workers' compensation laws but also other Federal and State laws, "* * * including laws regarding the reporting of occupational injuries and diseases."

On its face, this provision could be interpreted to mean that health plans and providers would now be subjected to the extensive reporting and record-keeping requirements of the Occupational Safety and Health Act of 1970, which presently applies only to employers. This significant expansion of OSHA's statutory authority would further burden health care providers with additional paperwork requirements, as well as potential OSH Act liability.

Repeal of McCarran-Ferguson

Subtitle E of title 5 of the committee bill repeals the McCarran-Ferguson Act for the provision of "health benefits" offered by insur-

ers. This provision is not needed for health care reform, and it is bad for both competition and consumers. A Thurmond amendment to strike the repeal from the bill was not adopted.

Subtitle E is not needed for health care reform because the McCarran-Ferguson Act covers only the "business of insurance," which has been narrowly defined to relate only to the spreading of policyholder risk and the relationship between the insurer and the insured. The "business of insurance" would not cover insurance companies which get into the business of providing medical care.

Subtitle E is bad for competition and consumers for several reasons. First, while it applies only to "health benefits," that term encompasses many lines of insurance and is far broader than merely health insurance. "Health benefits" which could be covered by this section are found in a wide range of insurance products, including workers' compensation, homeowners, auto, medical malpractice, and general liability.

Moreover, subtitle E is ambiguous. For example, it is not clear how it would apply to lines of insurance in which the medical benefit is only one portion of a larger policy.

Second, many of us strongly believe that any repeal of McCarran-Ferguson will inevitably lead to a decrease in competition, rather than the increase proponents claim. Instead, repeal of McCarran-Ferguson will likely lead to an increase in State regulation in an effort to come within the "State action doctrine," which is a less certain method of avoiding the Federal antitrust laws.

Such regulation may include greater control over pricing and other aspects of competition, which in a competitive environment should be left to the marketplace. Further, the insurance industry is now highly competitive as measured by the thousands of firms competing for business. Without the ability to engage in certain joint activities, especially regarding the sharing of information, many of the smaller companies may go out of business.

Finally, it should be recognized that McCarran-Ferguson is limited in scope. It simply gives the States the opportunity to regulate insurance and provides that the antitrust laws are applicable whenever the states fail to do so. If McCarran-Ferguson is repealed, it would only be a matter of time before new Federal regulation intrudes.

CONCLUDING COMMENTS

Nearly every serious attempt by minority members to address this bill's flaws during markup was thwarted. Moreover, even with three weeks of consideration, it was difficult to do more than scratch the surface of other, less visible issues.

We had hoped that, in the course of our deliberations, we would have been able to pull this bill toward the center. Minority members put forward amendment after amendment designed to reduce regulation, streamline bureaucracy, establish a more manageable and less specific benefits package, eliminate the employer mandate, and reduce opportunities for litigation.

Unfortunately, movement in any of these directions was minimal, and such improvements that did occur fell far, far short of the mark we needed to reach.

Fortunately, the Labor Committee is not the only player in the health reform debate, and the bill it reported is but one step in the process. For all practical purposes, this particular proposal has reached the end of its trail because it fails to offer a middle ground upon which the public or the majority of the Senate can comfortably stand.

NANCY LANDON KASSEBAUM.

STROM THURMOND.

JUDD GREGG.

DAVE DURENBERGER.

DAN COATS.

ORRIN HATCH.

CHANGES IN EXISTING LAW

In compliance with rule XXVI paragraph 12 of the Standing Rules of the Senate, the following provides a print of the statute or the part or section thereof to be amended or replaced (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

PUBLIC HEALTH SERVICE ACT

* * * * *

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* * * * *		

OFFICE OF BEHAVIORAL AND SOCIAL SCIENCES RESEARCH

SEC. 404A. [283c] (a) * * *

* * * * *

SEC. 404F. EXPENDITURES FOR HEALTH RESEARCH.

(a) *IN GENERAL.*—From amounts made available under section 3201 of the Health Security Act, the Secretary shall distribute—

(1) 2 percent of such amounts during any fiscal year to the Office of the Director of the National Institutes of Health to be allocated at the Director's discretion for the following activities:

(A) for carrying out the responsibilities of the Office of the Director, in including the Office of Research on Women's Health and the Office of Research on Minority Health, the Office of Alternative Medicine and the Office of Rare Diseases Research; and

(B) for construction and acquisition of equipment for or facilities of or used by the National Institutes of Health;

(2) 2 percent of such amounts for transfer to the National Center for Research Resources to carry out section 1502 of the National Institutes of Health Revitalization Act of 1993 concerning Biomedical and Behavioral Research Facilities;

(3) 1 percent of such amounts during any fiscal year for carrying out section 301 and part D of title IV with respect to health information communications; and

(4) the remainder of such amounts during any fiscal year to member institutes of the National Institutes of Health and Cen-

ters in the same proportion to the total amount received under this section, as the amount of annual appropriations under appropriations Acts for each member institute and Centers for the fiscal year bears to the total amount of appropriations under appropriations Acts for all member institutes and Centers of the National Institutes of Health for the fiscal year.

(b) **PLANS OF ALLOCATION.**—The amounts transferred under subsection (a) shall be allocated by the Director of NIH or the various directors of the institutes and centers, as the case may be, pursuant to allocation plans developed by the various advisory councils to such directors, after consultation with such directors.

* * * * *

SEC. 902. [299a] GENERAL AUTHORITIES AND DUTIES.

(a) * * *

* * * * *

(f) **RESEARCH ON HEALTH CARE REFORM.**—

(1) **IN GENERAL.**—In carrying out section 901(b), the Administrator shall conduct and support research on the reform of the health care system of the United States, as directed by the National Board.

(2) **PRIORITIES.**—In carrying out paragraph (1), the Administrator shall give priority to the following:

(A) Conducting and supporting research on the appropriateness and effectiveness of alternative clinical strategies (including community-based programs and preventive services), the quality and outcomes of care, and administrative simplification.

(B) Conducting and supporting research on the appropriateness and effectiveness of alternative community-based and clinical strategies including integrating preventive services into primary care, the effectiveness of preventive counseling and health education, and the efficacy and cost-effectiveness of clinical preventive services.

(C) Conducting and supporting research on consumer choice and information resources; the effects of health care reform on health delivery systems; workplace injury and illness prevention; intentional and unintentional injury prevention; methods for risk adjustment; factors influencing access to health care for vulnerable populations, including children, persons with low-income, persons with disabilities, or individuals with chronic or complex health conditions, and primary care.

(D) The development of clinical practice guidelines consistent with section 913, the dissemination of such guidelines consistent with section 903, and the assessment of the effectiveness of such guidelines.

SEC. 903. [299a-1] DISSEMINATION.

(a) **IN GENERAL.**—The Administrator shall—

(1) * * *

* * * * *

(4) as appropriate, provide technical assistance to State and local government and health agencies and Quality Improve-

ment Foundations and conduct liaison activities to such agencies to foster dissemination.

* * * * *

SEC. 904 [299a-2] HEALTH CARE TECHNOLOGY AND TECHNOLOGY ASSESSMENT.

(a) IN GENERAL.—In carrying out section 910(b), the administrator shall promote the development and application of appropriate health care technology assessments—

(1) * * *

* * * * *

(c) AGENDA AND PRIORITIES.—

(1) ESTABLISHMENT OF PRIORITIES.—In accordance with paragraph (2) the Administrator, in consultation with *the National Quality Council* and the Advisory Council established under section 921, shall establish an annual list of technology assessments under consideration by the Agency, including those assessments performed at the request of the Health Care Financing Administration and the Department of Defense and those assessments performed under subsections (d) and (f).

* * * * *

SEC. 912. [299b-1] DUTIES.

(a) * * *

* * * * *

(1) * * *

* * * * *

(4) include information on *outcomes*, risks and benefits of alternative strategies for prevention, diagnosis, treatment, and management of a given disease, disorder, or other health condition to the extent feasible given the availability of unbiased, reliable, and valid data; and

SEC. 914. [299b-3] ADDITIONAL REQUIREMENTS.

(a) PROGRAM AGENDA.—

* * * * *

(B) In providing for the agenda required in paragraph (1), including the priorities, the Administrator shall consult with *the National Quality Council*, the Administrator of the Health Care Financing Administration and otherwise act consistent with section 1142(b)(3) of the Social Security Act and relevant sections of the *Health Security Act*.

* * * * *

(c) DISSEMINATION.—The Administrator shall promote and support the dissemination of the guidelines, standards, performance measures, and review criteria described in section 912(a). Such dissemination shall be carried out through *Quality Improvement Foundations* and other organizations representing health care providers, organizations, accrediting bodies, and other appropriate entities.

* * * * *

(f) **RECOMMENDATIONS [TO ADMINISTRATOR].** The Director shall make recommendations to the [Administrator] *National Quality Council* on activities that should be carried out under section 902(a)(2) and under section 1142 of the Social Security Act, including recommendations of particular research projects that should be carried out with respect to—

* * * * *

SEC. 927. [299c-6] DEFINITIONS.

For purposes of this title:

(1) * * *

* * * * *

(5) *The term "National Quality Council" means the Council established under section 5001 of the Health Security Act.*

(6) *The term "Quality Improvement Foundations" means the Foundations established under section 5008 of the Health Security Act.*

[TITLE XXII—REQUIREMENTS FOR CERTAIN GROUP HEALTH PLANS FOR CERTAIN STATE AND LOCAL EMPLOYEES]

[SEC. 2201. [300bb-1] STATE AND LOCAL GOVERNMENTAL GROUP HEALTH PLANS MUST PROVIDE CONTINUATION COVERAGE TO CERTAIN INDIVIDUALS.

[(a) **IN GENERAL.**—In accordance with regulations which the Secretary shall prescribe, each group health plan that is maintained by any State that receives funds under this Act, by any political subdivision of such a State, or by any agency or instrumentality of such a State or political subdivision, shall provide, in accordance with this title, that each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event is entitled, under the plan, to elect, within the election period, continuation coverage under the plan.

[(b) **EXCEPTION FOR CERTAIN PLANS.**—Subsection (a) shall not apply to—

[(1) any group health plan for any calendar year if all employers maintaining such plan normally employed fewer than 20 employees on a typical business day during the preceding calendar year, or

[(2) any group health plan maintained for employees by the government of the District of Columbia or any territory or possession of the United States or any agency or instrumentality.

[SEC. 2202. [300bb-2] CONTINUATION COVERAGE.

[For purposes of section 2201, the term "continuation coverage" means coverage under the plan which meets the following requirements:

[(1) **TYPE OF BENEFIT COVERAGE.**—The coverage must consist of coverage which, as of the time the coverage is being provided, is identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred. If coverage is modified under the plan for any group of similarly situated bene-

ficiaries, such coverage shall also be modified in the same manner for all individuals who are qualified beneficiaries under the plan pursuant to this part in connection with such group.

[(2) PERIOD OF COVERAGE.—The coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:

[(A) MAXIMUM REQUIRED PERIOD.—

[(i) GENERAL RULE FOR TERMINATIONS AND REDUCED HOURS.—In the case of a qualifying event described in section 2203(2), except as provided in clause (ii), the date which is 18 months after the date of the qualifying event.

[(ii) SPECIAL RULE FOR MULTIPLE QUALIFYING EVENTS.—If a qualifying event occurs during the 18 months after the date of a qualifying event described in section 2203(2), the date which is 36 months after the date of the qualifying event described in section 2203(2).

[(iii) GENERAL RULE FOR OTHER QUALIFYING EVENTS.—In the case of a qualifying event not described in section 2203(2), the date which is 36 months after the date of the qualifying event.

In the case of an individual who is determined, under title II or XVI of the Social Security Act, to have been disabled at the time of a qualifying event described in section 2203(2), any reference in clause (i) or (ii) to 18 months with respect to such event is deemed a reference to 29 months, but only if the qualified beneficiary has provided notice of such determination under section 2206(3) before the end of such 18 months.

[(iv) QUALIFYING EVENT INVOLVING MEDICARE ENTITLEMENT.—In the case of an event described in section 2203(4) (without regard to whether such event is a qualifying event), the period of coverage for qualified beneficiaries other than the covered employee for such event or any subsequent qualifying event shall not terminate before the close of the 36-month period beginning on the date the covered employee becomes entitled to benefits under title XVIII of the Social Security Act.

[(B) END OF PLAN.—The date on which the employer ceases to provide any group health plan to any employee.

[(C) FAILURE TO PAY PREMIUM.—The date on which coverage ceases under the plan by reason of a failure to make timely payment of any premium required under the plan with respect to the qualified beneficiary. The payment of any premium (other than any payment referred to in the last sentence of paragraph (3)) shall be considered to be timely if made within 30 days after the date due or within such longer period as applies to or under the plan.

[(D) GROUP HEALTH PLAN COVERAGE [OR MEDICARE ENTITLEMENT], MEDICARE ENTITLEMENT, OR HEALTH SECURITY ACT ELIGIBILITY.—The date on which the qualified beneficiary first becomes, after the date of the election—

[(i) covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary, [or]

[(ii) entitled to benefits under title XVIII of the Social Security Act[.], or

[(iii) eligible for comprehensive health coverage described in section 1101 of the Health Security Act.

[(E) TERMINATION OF EXTENDED COVERAGE FOR DISABILITY.—In the case of a qualified beneficiary who is disabled at the time of a qualifying event described in section 2203(2), the month that begins more than 30 days after the date of the final determination under title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled.

[(3) PREMIUM REQUIREMENTS.—The plan may require payment of a premium for any period of continuation coverage, except that such premium—

[(A) shall not exceed 102 percent of the applicable premium for such period, and

[(B) may, at the election of the payor, be made in monthly installments.

In no event may the plan require the payment of any premium before the day which is 45 days after the day on which the qualified beneficiary made the initial election for continuation coverage. In the case of an individual described in the last sentence of paragraph (2)(A), any reference in subparagraph (A) of this paragraph to “102 percent” is deemed a reference to “150 percent” for any month after the 18th month of continuation coverage described in clause (i) or (ii) of paragraph (2)(A).

[(4) NO REQUIREMENT OF INSURABILITY.—The coverage may not be conditioned upon, or discriminate on the basis of lack of, evidence of insurability.

[(5) CONVERSION OPTION.—In the case of a qualified beneficiary whose period of continuation coverage expires under paragraph (2)(A), the plan must, during the 180-day period ending on such expiration date, provide to the qualified beneficiary the option of enrollment under a conversion health plan otherwise generally available under the plan.

[SEC. 2203. [300bb-3] QUALIFYING EVENT.

[For purposes of this title, the term “qualifying event” means, with respect to any covered employee, any of the following events which, but for the continuation coverage required under this title, would result in the loss of coverage of a qualified beneficiary:

[(1) The death of the covered employee.

[(2) The termination (other than by reason of such employee’s gross misconduct), or reduction of hours, of the covered employee’s employment.

[(3) The divorce or legal separation of the covered employee from the employee’s spouse.

[(4) The covered employee becoming entitled to benefits under title XVIII of the Social Security Act.

[(5) A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan.

[SEC. 2204. [300bb-4] APPLICABLE PREMIUM.]

[For purposes of this title—

[(1) IN GENERAL.—The term “applicable premium” means, with respect to any period of continuation coverage of qualified beneficiaries, the cost to the plan for such period of the coverage for similarly situated beneficiaries with respect to whom a qualifying event has not occurred (without regard to whether such cost is paid by the employer or employee).

[(2) SPECIAL RULE FOR SELF-INSURED PLANS.—To the extent that a plan is a self-insured plan—

[(A) IN GENERAL.—Except as provided in subparagraph (B), the applicable premium for any period of continuation coverage of qualified beneficiaries shall be equal to a reasonable estimate of the cost of providing coverage for such period for similarly situated beneficiaries which—

[(i) is determined on an actuarial basis, and

[(ii) takes into account such factors as the Secretary may prescribe in regulations.

[(B) DETERMINATION ON BASIS OF PAST COST.—If a plan administrator elects to have this subparagraph apply, the applicable premium for any period of continuation coverage of qualified beneficiaries shall be equal to—

[(i) the cost to the plan for similarly situated beneficiaries for the same period occurring during the preceding determination period under paragraph (3), adjusted by

[(ii) the percentage increase or decrease in the implicit price deflator of the gross national product (calculated by the Department of Commerce and published in the Survey of Current Business) for the 12-month period ending on the last day of the sixth month of such preceding determination period.

[(C) SUBPARAGRAPH (B) NOT TO APPLY WHERE SIGNIFICANT CHANGE.—A plan administrator may not elect to have subparagraph (B) apply in any case in which there is any significant difference, between the determination period and the preceding determination period, in coverage under, or in employees covered by, the plan. The determination under the preceding sentence for any determination period shall be made at the same time as the determination under paragraph (3).

[(3) DETERMINATION PERIOD.—The determination of any applicable premium shall be made for a period of 12 months and shall be made before the beginning of such period.

[SEC. 2205. [300bb-5] ELECTION.]

[For purposes of this title—

[(1) ELECTION PERIOD.—The term “election period” means the period which—

[(A) begins not later than the date on which coverage terminates under the plan by reason of a qualifying event,

[(B) is of at least 60 days’ duration, and

[(C) ends not earlier than 60 days after the later of—

[(i) the date described in subparagraph (A), or

[(ii) in the case of any qualified beneficiary who receives notice under section 2206(4), the date of such notice.

[(2) EFFECT OF ELECTION ON OTHER BENEFICIARIES.—Except as otherwise specified in an election, any election of continuation coverage by a qualified beneficiary described in subparagraph (A)(i) or (B) of section 2208(3) shall be deemed to include an election of continuation coverage on behalf of any other qualified beneficiary who would lose coverage under the plan by reason of the qualifying event. If there is a choice among types of coverage under the plan, each qualified beneficiary is entitled to make a separate selection among such types of coverage.

[SEC. 2206. [300bb-6] NOTICE REQUIREMENTS.

[In accordance with regulations prescribed by the Secretary—

[(1) the group health plan shall provide, at the time of commencement of coverage under the plan, written notice to each covered employee and spouse of the employee (if any) of the rights provided under this subsection,

[(2) the employer of an employee under a plan must notify the plan administrator of a qualifying event described in paragraph (1), (2), or (4) of section 2203 within 30 days of the date of the qualifying event,

[(3) each covered employee or qualified beneficiary is responsible for notifying the plan administrator of the occurrence of any qualifying event described in paragraph (3) or (5) of section 2203 within 60 days after the date of the qualifying event and each qualified beneficiary who is determined, under title II or XVI of the Social Security Act, to have been disabled at the time of a qualifying event described in section 2203(2) is responsible for notifying the plan administrator of such determination within 60 days after the date of the determination and for notifying the plan administrator within 30 days after the date of any final determination under such title or titles that the qualified beneficiary is no longer disabled, and

[(4) the plan administrator shall notify—

[(A) in the case of a qualifying event described in paragraph (1), (2), or (4) of section 2203, any qualified beneficiary with respect to such event, and

[(B) in the case of a qualifying event described in paragraph (3) or (5) of section 2203 where the covered employee notifies the plan administrator under paragraph (3), any qualified beneficiary with respect to such event,

of such beneficiary's rights under this subsection.¹

For purposes of paragraph (4), any notification shall be made within 14 days of the date on which the plan administrator is notified under paragraph (2) or (3), whichever is applicable, and any such notification to an individual who is a qualified beneficiary as the spouse of the covered employee shall be treated as notification to all other qualified beneficiaries residing with such spouse at the time such notification is made.

[SEC. 2207. [300bb-7] ENFORCEMENT.

Any individual who is aggrieved by the failure of a State, political subdivision, or agency or instrumentality thereof, to comply with the requirements of this title may bring an action for appropriate equitable relief.

[SEC. 2208. [300bb-8] DEFINITIONS.

For purposes of this title—

[(1) **GROUP HEALTH PLAN.**—The term “group health plan” has the meaning given such term in section 162(i)(2) of the Internal Revenue Code of 1986.

[(2) **COVERED EMPLOYEE.**—The term “covered employee” means an individual who is (or was) provided coverage under a group health plan by virtue of the performance of services by the individual for 1 or more persons maintaining the plan (including as an employee defined in section 401(c)(1) of the Internal Revenue Code of 1986).

[(3) **QUALIFIED BENEFICIARY.**—

[(A) **IN GENERAL.**—The term “qualified beneficiary” means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan—

[(i) as the spouse of the covered employee, or

[(ii) as the dependent child of the employee.

[(B) **SPECIAL RULE FOR TERMINATIONS AND REDUCED EMPLOYMENT.**—In the case of a qualifying event described in section 2203(2), the term “qualified beneficiary” includes the covered employee.

[(C) **SPECIAL RULE FOR INDIVIDUALS COVERED BY HEALTH SECURITY ACT.**—The term “qualified beneficiary” shall not include any individual who, upon termination of coverage under a group health plan, is eligible for comprehensive health coverage described in section 1101 of the Health Security Act.

[(4) **PLAN ADMINISTRATOR.**—The term “plan administrator” has the meaning given the term “administrator” by section 3(16)(A) of the Employee Retirement Income Security Act of 1974.]

TITLE XXVII—LONG-TERM CARE

PART 1—LONG-TERM CARE INSURANCE STANDARDS

Subpart A—Promulgation of Standards and Model Benefits

SEC. 2701. STANDARDS.

(a) **APPLICATION OF STANDARDS.**—

(1) **NAIC.**—

(A) **IN GENERAL.**—The Secretary shall request that the National Association of Insurance Commissioners (hereafter in this part referred to as the “NAIC”)—

(i) develop specific standards that incorporate the requirements of this part; and

(ii) report to the Secretary concerning such standards.

(B) *APPLICATION.*—If, within 12 months after the date of the enactment of this part, the NAIC develops the model standards under subparagraph (A)(i), the Secretary shall have 60 days in which to determine whether such standards implement the requirements of this part. If such standards are approved by the Secretary, they shall be the standards that apply as provided in this part.

(2) *DEFAULT.*—If the NAIC does not promulgate the model standards under paragraph (1) by the deadline established in that paragraph, the Secretary shall promulgate, within 12 months after such deadline, a regulation that provides standards that incorporate the requirements of this part and such standards shall apply as provided for in this part.

(3) *RELATIONS TO STATE LAW.*—Nothing in this part shall be construed as preventing a State from applying standards that provide greater protection to policyholders of long-term care insurance policies than the standards promulgated under this part, except that such State standards may not be inconsistent or in conflict with any of the requirements of this part.

(b) *DEADLINE FOR APPLICATION OF STANDARDS.*—

(1) *IN GENERAL.*—Subject to paragraph (2), the date specified in this subsection for a State is—

(A) the date the State adopts the standards established under subsection (a)(1); or

(B) the date that is 1 year after the first day of the first regular legislative session, that begins after the date such standards are first established under subsection (a)(2); whichever is earlier.

(2) *STATE REQUIRING LEGISLATION.*—In the case of a State which the Secretary identifies, in consultation with the NAIC, as—

(A) requiring State legislation (other than legislation appropriating funds) in order for the standards established under subsection (a) to be applied; but

(B) having a legislature which is not scheduled to meet within 1 year following the beginning of the next regular legislative session in which such legislation may be considered;

the date specified in this subsection is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1995. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(c) *ITEMS INCLUDED IN STANDARDS.*—The standards promulgated under subsection (a) shall include—

(1) minimum Federal standards for long-term care insurance consistent with the provisions of this part;

(2) standards for the enhanced protection of consumers with long-term care insurance; and

(3) procedures for the modification of the standards established under paragraph (1) in a manner consistent with future laws to expand existing Federal or State long-term care benefits or establish a comprehensive Federal or State long-term care benefit program.

(d) **CONSULTATION.**—In establishing standards and models of benefits under this section, the Secretary shall, after consultation with representatives of carriers, consumer groups, and providers of long-term care services—

(1) recommend the appropriate inflationary index to be used with respect to the inflation protection benefit portion of the standards;

(2) recommend the uniform needs assessment mechanism to be used in determining the eligibility of individuals for benefits under a policy;

(3) recommend appropriate standards for the regulation of the insurance aspects of supported housing arrangements; and

(4) perform such other activities as determined appropriate by the Secretary.

Subpart B—Establishment and Implementation of Long-Term Care Insurance Policy Standards

SEC. 2711. IMPLEMENTATION FOR POLICY STANDARDS.

(a) IN GENERAL.—

(1) **REGULATORY PROGRAM.**—No long-term care policy (as defined in section (2721)) may be issued, sold, or offered for sale as a long-term care insurance policy in a State on or after the date specified in section 2701(b) unless—

(A) the Secretary determines that the State has established a regulatory program that—

(i) provides for the application and enforcement of the standards established under section 2701(a); and

(ii) complies with the requirements of subsection (b); by the date specified in section 2701(b), and the policy has been approved by the State commissioner or superintendent of insurance under such program; or

(B) if the State has not established such a program, or if the State's regulatory program has been decertified, the policy has been certified by the Secretary (in accordance with such procedures as the Secretary may establish) as meeting the standards established under section 2701(a) by the date specified in section 2701(b).

For purposes of this subsection, the advertising or soliciting with respect to a policy, directly or indirectly, shall be deemed the offering for sale of the policy.

(2) **REVIEW OF STATE REGULATORY PROGRAMS.**—The Secretary shall review regulatory programs described in paragraph (1)(A) at least biannually to determine if they continue to provide for the application and enforcement of the standards and procedures established under section 2701(a) and (b). If the Secretary determines that a State regulatory program no longer meets such standards and requirements, before making a final determination, the Secretary shall provide the State an opportunity

to adopt such a plan of correction as would permit the program to continue to meet such standards and requirements. If the Secretary makes a final determination that the State regulatory program, after such an opportunity, fails to meet such standards and requirements, the Secretary shall assume responsibility under paragraph (1)(B) with respect to certifying policies in the State and shall exercise full authority under section 2701 for carriers, agents, or associations or its subsidiary in the State plans in the State.

(b) **ADDITIONAL REQUIREMENTS FOR APPROVAL OF STATE REGULATORY PROGRAMS.**—For purposes of subsection (a)(1)(A)(ii), the requirements of this subsection for a State regulatory program are as follows:

(1) **ENFORCEMENT.**—The enforcement under the program—

(A) shall be designed in a manner so as to secure compliance with the standards within 30 days after the date of a finding of noncompliance with such standards; and

(B) shall provide for notice in the annual report required under paragraph (5) to the Secretary of cases where such compliance is not secured within such 30-day period.

(2) **PROCESS.**—The enforcement process under each State regulatory program shall provide for—

(A) procedures for individuals and entities to file written, signed complaints respecting alleged violations of the standards;

(B) responding to such complaints within 90 days;

(C) the investigation of—

(i) those complaints which have a reasonable probability of validity, and

(ii) such other alleged violations of the standards as the program finds appropriate; and

(D) the imposition of appropriate sanctions (which include, in appropriate cases, the imposition of a civil money penalty as provided for in section 2718) in the case of a carrier, agent, or association or its subsidiary determined to have violated the standards.

(3) **PRIVATE ACTIONS.**—An individual may commence a civil action in an appropriate State or United States district court to enforce the provisions of this title and may be awarded appropriate relief and reasonable attorney's fees.

(4) **CONSUMER ACCESS TO COMPLIANCE INFORMATION.**—

(A) **IN GENERAL.**—A State regulatory program must provide for consumer access to complaints filed with the State commissioner or superintendent of insurance with respect to long-term care insurance policies.

(B) **CONFIDENTIALITY.**—The access provided under subparagraph (A) shall be limited to the extent required to protect the confidentiality of the identity of individual policyholders.

(5) **PROCESS FOR APPROVAL OF PREMIUMS.**—

(A) **IN GENERAL.**—Each State regulatory program shall—

(i) provide for a process for approving or disapproving proposed premium increases or decreases with respect to long-term care insurance policies; and

(ii) establish a policy for receipt and consideration of public comments before approving such a premium increase or decrease.

(B) **CONDITIONS FOR APPROVAL.**—No premium increase shall be approved (or deemed approved) under subparagraph (A) unless the proposed increase is accompanied by an actuarial memorandum which—

(i) includes a description of the assumptions that justify the increase, including a financial report on expenditures;

(ii) contains such information as may be required under the Standards; and

(iii) is made available to the public.

(C) **APPLICATION.**—Except as provided in subparagraph (D), this paragraph shall not apply to a group long-term care insurance policy issued to a group described in section 4(E)(1) of the NAIC Long Term Care Insurance Model Act (effective January 1991), except that such group policy shall, pursuant to guidelines developed by the NAIC, provide notice to policyholders and certificate holders of any premium change under such group policy.

(D) **EXCEPTION.**—Subparagraph (C) shall not apply to—

(i) group conversion policies;

(ii) the group continuation feature of a group policy if the insurer separately rates employee and continuation coverages; and

(iii) group policies where the function of the employer is limited solely to collecting premiums (through payroll deductions or dues checkoff) and remitting them to the insurer.

(E) **CONSTRUCTION.**—Nothing in this paragraph shall be construed as preventing the NAIC from promulgating standards, or a State from enacting and enforcing laws, with respect to premium rates or loss ratios for all, including group, long-term care insurance policies.

(6) **ANNUAL REPORTS.**—Each State regulatory program shall provide for annual reports to be submitted to the Secretary on the implementation and enforcement of the standards in the State, including information concerning violations in excess of 30 days.

(7) **ACCESS TO OTHER INFORMATION.**—The State regulatory program must provide for consumer access to actuarial memoranda, including financial information, provided under paragraph (4).

(8) **DEFAULT.**—In the case of a State without a regulatory program approved under subsection (a), the Secretary shall provide for the enforcement activities described in subsection (c).

(c) **SECRETARIAL ENFORCEMENT AUTHORITY.**—

(1) **IN GENERAL.**—The Secretary shall exercise authority under this section in the case of a State that does not have a regulatory program approved under this section.

(2) **COMPLAINTS AND INVESTIGATIONS.**—The Secretary shall establish procedures—

(A) for individuals and entities to file written, signed complaints respecting alleged violations of the requirements of this part;

(B) for responding on a timely basis to such complaints; and

(C) for the investigation of—

(i) the complaints that have a reasonable probability of validity; and

(ii) such other alleged violations of the requirements of this part as the Secretary determines to be appropriate.

In conducting investigations under this subsection, agents of the Secretary shall have reasonable access necessary to enable such agents to examine evidence of any carrier, agent, or association or its subsidiary being investigated.

(3) HEARINGS.—

(A) *IN GENERAL*.—Prior to imposing an order described in paragraph (4) against a carrier, agent, or association or its subsidiary under this section for a violation of the requirements of this part, the Secretary provide the carrier, agent, association or subsidiary with notice and, upon request made within a reasonable time (of not less than 30 days, as established by the Secretary by regulation) of the date of the notice, a hearing respecting the violation.

(B) *CONDUCT OF HEARING*.—Any hearing requested under subparagraph (A) shall be conducted before an administrative law judge. If no hearing is so requested, the Secretary's imposition of the order shall constitute a final and unappealable order.

(C) *AUTHORITY IN HEARINGS*.—In conducting hearings under this paragraph—

(i) agents of the Secretary and administrative law judges shall have reasonable access necessary to enable such agents and judges to examine evidence of any carrier, agent, or association or its subsidiary being investigated; and

(ii) administrative law judges, may, if necessary, compel by subpoena the attendance of witnesses and the production of evidence at any designated place or hearing.

In case of contumacy or refusal to obey a subpoena lawfully issued under this subparagraph and upon application of the Secretary, an appropriate district court of the United States may issue an order requiring compliance with such subpoena and any failure to obey such order may be punished by such court as a contempt thereof.

(D) *ISSUANCE OF ORDERS*.—If an administrative law judge determines in a hearing under this paragraph, upon the preponderance of the evidence received, that a carrier, agent, or association or its subsidiary named in the complaint has violated the requirement of this part, the administrative law judge shall state the findings of fact and issue and cause to be served on such carrier, agent, association, or subsidiary an order described in paragraph (4).

(4) **CEASE AND DESIST ORDER WITH CIVIL MONEY PENALTY.**—

(A) **IN GENERAL.**—Subject to the provisions of subparagraphs (b) through (F), an order under this paragraph—

(i) shall require the agent, association or its subsidiary, or a carrier—

(I) to cease and desist from such violations; and

(II) to pay a civil penalty in an amount not to exceed \$15,000 in the case of each agent, and not to exceed \$25,000 for each association, or its subsidiary or a carrier for each such violation; and

(ii) may require the agent, association or its subsidiary, or a carrier to take such other remedial action as is appropriate.

(B) **CORRECTIONS WITHIN 30 DAYS.**—No order shall be imposed under this paragraph by reason of any violation if the carrier, agent, association, or its subsidiary establishes to the satisfaction of the Secretary that—

(i) such violation was due to reasonable cause and was not intentional and was not due to willful neglect; and

(ii) such violation is corrected within the 30-day period beginning on the earliest date the carrier, agent, association, or subsidiary knew, or exercising reasonable diligence could have known, that such a violation was occurring.

(C) **WAIVER BY SECRETARY.**—In the case of a violation under this part that is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the civil money penalty imposed under subparagraph (A)(i)(II) to the extent that payment of such penalty would be grossly excessive relative to the violation involved and to the need for deterrence of violations.

(D) **ADMINISTRATIVE APPELLATE REVIEW.**—The decision and order of an administrative law judge under this paragraph shall become the final agency decision and order of the Secretary unless, within 30 days, the Secretary modifies or vacates the decision and order, in which case the decision and order of the Secretary shall become a final order under this paragraph.

(E) **JUDICIAL REVIEW.**—A carrier, agent, association, or its subsidiary or any other individual adversely affected by a final order issued under this paragraph may, within 45 days after the date the final order is issued, file a petition in the Court of Appeals for the appropriate circuit for review of the order.

(F) **ENFORCEMENT OF ORDERS.**—If a carrier, agent, or association or its subsidiary fails to comply with a final order issued under this paragraph against the carrier, agent, association, or subsidiary after opportunity for judicial review under subparagraph (E), the Secretary shall file a suit to seek compliance with the order in any appropriate district court of the United States. In any such suit, the validity and appropriateness of the final order shall not be subject to review.

SEC. 2712. REGULATION OF SALES PRACTICES.

(A) DUTY OF GOOD FAITH AND FAIR DEALING.—

(1) *IN GENERAL.*—Each agent (as defined in section 2733) or association that is selling or offering for sale a long-term care insurance policy has the duty of good faith and fair dealing to the purchaser or potential purchaser of such a policy.

(2) *POLICY REPLACEMENT FORM.*—With respect to any person who elects to replace a change in a long-term care insurance policy, the individual that is selling such policy shall ensure that such person completes a policy replacement form developed by the NAIC. A copy of such form shall be provided to such person and additional copies shall be delivered by the selling individual to the old policy issuer and the new issuer and kept on file for inspection by the State regulatory agency.

(3) *PROHIBITED PRACTICES.*—An agent or association is considered to have violated paragraph (1) if the agent or association engages in any of the following practices:

(A) *TWISTING.*—Knowingly making any misleading representation (including the inaccurate completion of medical histories) or incomplete or fraudulent comparison of any long-term care insurance policy of insurers for the purpose of inducing, or tending to induce, any person to retain or effect a change with respect to a long-term care insurance policy.

(B) *HIGH PRESSURE TACTICS.*—Employing any method of marketing having the effect of, or intending to, induce the purchase of long-term care insurance policy through force, fright, threat or undue pressure, whether explicit or implicit.

(C) *COLD LEAD ADVERTISING.*—Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

(D) *OTHERS.*—Engaging in such other practices determined inappropriate under guidelines issued by the NAIC.

(b) *FINANCIAL STANDARDS.*—The NAIC shall develop recommended financial minimum standards (including both income and asset criteria) for the purpose of advising individuals as to the costs and amounts of insurance needed when considering the purchase of a long-term care insurance policy.

(c) *PROHIBITION OF SALE OR ISSUANCE TO MEDICAID BENEFICIARIES.*—An agent, an association, or a carrier may not knowingly sell or issue a long-term care insurance policy to an individual who is eligible for medical assistance under title XIX of the Social Security Act.

(d) *PROHIBITION OF SALE OR ISSUANCE OF DUPLICATE SERVICE BENEFIT POLICIES.*—An agent, association, or its subsidiary, or a carrier may not sell or issue a service-benefit long-term care insurance policy to an individual—

(1) knowing that the policy provides for coverage that duplicates coverage already provided in another service-benefit long-term care insurance policy held by such individual (unless the policy is intended to replace such other policy); or

(2) for the benefit of an individual unless the individual (or a representative of the individual) provides a written statement to the effect that the coverage—

(A) does not duplicate other coverage in effect under a service-benefit long-term care insurance policy; or

(B) will replace another service-benefit long-term care insurance policy.

In this subsection, the term “service-benefit long-term care insurance policy” means a long-term care insurance policy which provides for benefits based on the type and amount of services furnished.

(e) **PROHIBITION BASED ON ELIGIBILITY FOR OTHER BENEFITS.**—A carrier may not sell or issue a long-term care insurance policy that reduces, limits or coordinates the benefits provided under the policy on the basis that the policyholder has or is eligible for other long-term care insurance coverage or benefits.

(f) **PROVISION OF OUTLINE OF COVERAGE.**—No agent, association or its subsidiary, or carrier may sell or offer for a sale a long-term care insurance policy without providing to every individual purchaser or potential purchaser (or representative) an outline of coverage that complies with the standards established under section 2701(a).

(g) **PENALTIES.**—Any agent who sells, offers for sale, or issues a long-term care insurance policy in violation of this section may be imprisoned not more than 5 years, or fined in accordance with title 18, United States Code, and, in addition, is subject to a civil money penalty of not to exceed \$15,000 for each such violation. Any association or its subsidiary or carrier that sells, offers for sale, or issues a long-term care insurance policy in violation of this section may be fined in accordance with title 18, United States Code, and, in addition, is subject to a civil money penalty of not to exceed \$25,000 for each violation. Nothing in this subsection shall be construed as preempting or otherwise limiting the penalties that may be imposed by a State for conduct that violates this section.

(h) **AGENT TRAINING AND CERTIFICATION REQUIREMENTS.**—The NAIC, shall establish requirements for long-term care insurance agent training and certification that—

(1) specify requirements for training insurance agents who desire to sell or offer for sale long-term care insurance policies; and

(2) specify procedures for certifying and recertifying agents who have completed such training and who are as qualified to sell or offer for sale long-term care insurance policies.

SEC. 2713. ADDITIONAL RESPONSIBILITIES FOR CARRIERS.

(a) **REFUND OF PREMIUMS.**—If an application for a long-term care insurance policy (or for a certificate under a group long-term care insurance policy) is denied or an applicant returns a policy or certificate within 30 days of the date of its issuance pursuant to subsection 2717, the carrier shall refund directly to the applicant, or in the case of an employer to whomever remits the premium, and not by delivery by the agent, not later than 30 days after the date of the denial or return, any premiums paid with respect to such a policy (or certificate).

(b) **MAILING OF POLICY.**—If an application for a long-term care insurance policy (or for a certificate under a group long-term care insurance policy) is approved, the carrier shall provide every individual applicant the policy (or certificate) of insurance and outline of coverage not later than 30 days after the date of the approval.

(c) **INFORMATION ON DENIALS OF CLAIMS.**—If a claim under a long-term care insurance policy is denied, the carrier shall, within 15 days of the date of a written request by the policyholder or certificate holder (or representative)—

(1) provide a written explanation of the reasons for the denial;

(2) make available all medical and patient records directly relating to such denial; and

(3) provide a written explanation of the manner in which to appeal the denial.

Except as provided in subsection (e) section of 2715, no claim under such a policy may be denied on the basis of a failure to disclose a condition at the time of issuance of the policy if the application for the policy failed to request information respecting the condition.

(d) **REPORTING OF INFORMATION.**—A carrier that issues one or more long-term care insurance policies shall periodically (not less often than annually) report, in a form and in a manner determined by the NAIC, to the Commissioner, superintendent or director of insurance of each State in which the policy is delivered, and shall make available to the Secretary, upon request, information in a form and manner determined by the NAIC concerning—

(1) the long-term care insurance policies of the carrier that are in force;

(2) the most recent premiums for such policies and the premiums imposed for such policies since their initial issuance;

(3) the lapse rate, replacement rate, and rescission rates by policy;

(4) the names of that 10 percent of its agents that—

(A) have the greatest lapse and replacement rate; and

(B) have produced at least \$50,000 of long-term care issuance sales in the previous year; and

(5) the claims denied (expressed as a number and as a percentage of claims submitted) by policy.

Information required under this subsection shall be reported in a format specified in the standards established under section 2701(a). For purposes of paragraph (3), there shall be included (but reported separately) data concerning lapses due to the death of the policyholder. For purposes of paragraph (4), there shall not be included as a claim any claim that is denied solely because of the failure to meet a deductible, waiting period, or exclusionary period.

(e) **STANDARDS ON COMPENSATION FOR SALE OF POLICIES.**—

(1) **IN GENERAL.**—A carrier that issues one or more long-term care insurance policies may provide a commission or other compensation to an agent or other representative for the sale of such a policy only if the first year commission or other first year compensation to be paid does not exceed 200 percent of the commission or other compensation paid for selling or servicing the policy in the second year, or if the first year commission or other compensation to be paid does not exceed 50 percent of the

premium paid on the first year policy, until the NAIC promulgates mandatory standards concerning compensation for the sale of such policies.

(2) **SUBSEQUENT YEARS.**—The commission or other compensation provided for the sale of long-term care insurance policies in years subsequent to the first year of the policy shall be the same as that provided in the second subsequent year and shall be provided for no fewer than 5 subsequent years.

(3) **LIMITATION.**—No carrier shall provide compensation to its agents for the sale of a long-term care insurance policy and no agent shall receive compensation greater than the renewal compensation payable by the replacing carrier on renewal policies if an existing policy is replaced.

(4) **COMPENSATION DEFINED.**—As used in this subsection, the term "compensation" includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of the policy, including but not limited to deferred compensation, bonuses, gifts, prizes, awards, and finders fees.

SEC. 2714. RENEWABILITY STANDARDS FOR ISSUANCE, AND BASIC FOR CANCELLATION OF POLICIES.

(a) **IN GENERAL.**—No long-term care insurance policy may be canceled or nonrenewed for any reason other than nonpayment of premium, material misrepresentation or fraud.

(b) **CONTINUATION AND CONVERSION RIGHTS FOR GROUP POLICIES.**—

(1) **IN GENERAL.**—Each group long-term care insurance policy shall provide covered individuals with a basis for continuation or conversion in accordance with this subsection.

(2) **BASIS FOR CONTINUATION.**—For purposes of paragraph (1), a policy provides a basis for continuation of coverage if the policy maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. A group policy which restricts provision of benefits and services to or contains incentives to use certain providers or facility, may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy.

(3) **BASIS FOR CONVERSION.**—For purposes of paragraph (1), a policy provides a basis for conversion of coverage if the policy entitles each individual—

(A) whose coverage under the group policy would otherwise be terminated for any reason; and

(B) who has been continuously insured under the policy (or group policy which was replaced) for at least 6 months before the date of the termination;

to issuance of a policy providing benefits identical to, substantially equivalent to, or in excess of, those of the policy being terminated, without evidence of insurability.

(4) **TREATMENT OF SUBSTANTIAL EQUIVALENCE.**—In determining under this subsection whether benefits are substantially equivalent, consideration should be given to the difference between managed care and non-managed care plans.

(5) **GROUP REPLACEMENT OF POLICIES.**—If a group long-term care insurance policy is replaced by another long-term care in-

insurance policy purchased by the same policyholder, the succeeding issuer shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for pre-existing conditions that would have been covered under the group policy being replaced.

(c) **STANDARDS FOR ISSUANCE.**—

(1) **IN GENERAL.**—

(A) **GUARANTEE.**—An agent, association or carrier that sells or issues long-term care insurance policies shall guarantee that such policies shall be sold or issued to an individual, or eligible individual in the case of a group plan, if such individual meets the minimum medical underwriting requirements of such policy.

(B) **PREMIUM FOR CONVERTED POLICY.**—If a group policy from which conversion is made is a replacement for a previous group policy, the premium for the converted policy shall be calculated on the basis of the insured's age at the inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

(2) **UPGRADE FOR CURRENT POLICIES.**—The NAIC shall establish standards, including those providing guidance on medical underwriting and age rating, with respect to the access of individuals to policies offering upgraded benefits.

(3) **RATE STABILIZATION.**—The NAIC shall establish standards for premium rate stabilization.

(d) **EFFECT OF INCAPACITATION.**—

(1) **IN GENERAL.**—

(A) **PROHIBITION.**—Except as provided in paragraph (2), a long-term care insurance policy in effect as of the effective date of the standards established under section 2701(a) may not be canceled for nonpayment if the policy holder is determined by a long-term care provider, physician or other health care provider, independent of the issuer of the policy, to be cognitively or mentally incapacitated so as to not make payments in a timely manner.

(B) **REINSTATEMENT.**—A long-term care policy shall include a provision that provides for the reinstatement of such coverage, in the event of lapse, if the insurer is provided with proof of cognitive or mental incapacitation. Such reinstatement option shall remain available for a period of not less than 5 months after termination and shall allow for the collection of past due premium.

(2) **PERMITTED CANCELLATION.**—A long-term care insurance policy may be canceled under paragraph (1) for nonpayment if—

(A) the period of such nonpayment is in excess of 30 days; and

(B) notice of intent to cancel is provided to the policyholder or designated representative of the policy holder not

less than 30 days prior to such cancellation, except that notice may not be provided until the expiration of 30 days after a premium is due and unpaid.

Notice under this paragraph shall be deemed to have been given as of 5 days after the mailing date.

SEC. 2715. BENEFIT STANDARDS.

(a) **USE OF STANDARD DEFINITIONS AND TERMINOLOGY, UNIFORM FORMAT, AND STANDARD BENEFITS.**—Each long-term care insurance policy shall, with respect to services, providers or facilities, pursuant to standards established under section 2701(a)—

(1) use uniform language and definitions, except that such language and definitions may take into account the differences between States with respect to definitions and terminology used for long-term care services and providers; and

(2) use a uniform format for presenting the outline of coverage under such a policy; as prescribed under guidelines issued by the NAIC and periodically updated.

(b) **DISCLOSURE.**—

(1) **OUTLINE OF COVERAGE.**—

(A) **REQUIREMENT.**—Each carrier that sells or offers for sale a long-term care insurance policy shall provide an outline of coverage to each individual policyholder under such policy that meets the applicable standards established pursuant to section 2701(a), complies with the requirements of subparagraph (B), and is in a uniform format as prescribed in guidelines issued by the NAIC and periodically updated.

(B) **CONTENTS.**—The outline of coverage for each long-term care insurance policy shall include at least the following:

(i) A description of the benefits and coverage under the policy.

(ii) A statement of the exclusions, reductions, and limitations contained in the policy.

(iii) A statement of the terms under which the policy (or certificate) may be continued in force or discontinued, the terms for continuation or conversion, and any reservation in the policy of a right to change premiums.

(iv) Consumer protection information, including the manner in which to file a claim and to register complaints.

(v) A statement, in bold face type on the face of the document in language that is understandable to an average individual, that the outline of coverage is a summary only, not a contract of insurance, and that the policy (or master policy) contains the contractual provisions that govern, except that such summary shall substantially and accurately reflect the contents of the policy or the master policy.

(vi) A description of the terms, specified in section 2717, under which a policy or certificate may be returned and premium refunded.

(vii) *Information on—*

(I) *national average costs for nursing facility and home health care and information (in graphic form) on the relationship of the value of the benefits provided under the policy to such national average costs and State average costs; and*

(II) *other public and private long-term care insurance products and long-term care programs where made available by the Federal Government or by a State government.*

(viii) *A statement of the percentage limit on annual premium increases that is provided under the policy pursuant to this section.*

(2) **CERTIFICATES.**—*A certificate issued pursuant to a group long-term care insurance policy shall include—*

(A) *a description of the principal benefits and coverage provided in the policy;*

(B) *a statement of the principal exclusions, reductions, and limitations contained in the policy; and*

(C) *A statement that the group master policy determines governing contractual provisions.*

(3) **LONG-TERM CARE AS PART OF LIFE INSURANCE.**—*In the case of a long-term care insurance policy issued as a part of, or a rider on, a life insurance policy, at the time of policy delivery there shall be provided a policy summary that includes—*

(A) *an explanation of how the long-term care benefits interact with other components of the policy (including deductions from death benefits);*

(B) *an illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits (if any) for each covered person; and*

(C) *any exclusions, reductions, and limitations on benefits of long-term care.*

(4) **ADDITIONAL INFORMATION.**—*The NAIC shall develop recommendations with respect to informing consumers of the long-term economic viability of carriers issuing long-term care insurance policies.*

(c) **LIMITING CONDITIONS ON BENEFITS; MINIMUM BENEFITS.**—

(1) **IN GENERAL.**—*A long-term care insurance policy may not condition or limit eligibility—*

(A) *for benefits for a type of services to the need for or receipt of any other services;*

(B) *for any benefit on the medical necessity for such benefit;*

(C) *for benefits furnished by licensed or certified providers in compliance with conditions which are in addition to those required for licensure or certification under State law, except that if no State licensure or certification laws exists, in compliance with qualifications developed by the NAIC; or*

(D) *for residential care (if covered under the policy) only—*

(i) *to care provided in facilities which provide a higher level of care; or*

(ii) to care provided in facilities which provide for 24-hour or other nursing care not required in order to be licensed by the State.

(2) **HOME HEALTH CARE OR COMMUNITY-BASED SERVICES.**—If a long-term care insurance policy provides benefits for the payment of specified home health care or community-based services, the policy—

(A) may not limit such benefits to services provided by registered nurses or licensed practical nurses;

(B) may not require benefits for such services to be provided by a nurse or therapist that can be provided by a home health aide or licensed or certified home care worker, except that if no State licensure or certification laws exists, in compliance with qualifications developed by the NAIC;

(C) may not limit such benefits to services provided by agencies or providers certified under title XVIII of the Social Security Act; and

(D) must provide, at a minimum, benefits for personal care services (including home health aide and home care worker services as defined by the NAIC) home health services, adult day care, and respite care in an individual's home or in another setting in the community, or any of these benefits on a respite care basis.

(3) **NURSING FACILITY SERVICES.**—If a long-term care insurance policy provides benefits for the payment of specified nursing facility services, the policy must provide such benefits with respect to all nursing facilities (as defined in section 1919(a) of the Social Security Act or until such time as subsequently provided for by the NAIC in establishing uniform language and definitions under section 2715(a)(1) in the State.

(4) **PER DIEM POLICIES.**—

(A) **DEFINITION.**—For purposes of this part, the term “per diem long-term care insurance policy” means a long-term care insurance policy (or certificate under a group long-term care insurance policy) that provides for benefit payments on a periodic basis due to cognitive impairment or loss of functional capacity without regard to the expenses incurred or services rendered during the period to which the payments relate.

(B) **LIMITATION.**—No per diem long-term care insurance policy (or certificate) may condition, limit or otherwise exclude benefit payments based on the receipt of any type services from any type providers of long-term care service providers.

(d) **PROHIBITION OF DISCRIMINATION.**—A long-term care insurance policy may not treat differently benefits under the policy in the case of an individual with Alzheimer's disease, with any related progressive degenerative dementia of an organic origin, with any organic or inorganic mental illness, or with mental retardation or any other cognitive or mental impairment from an individual having a functional impairment for which benefits may be made available.

(e) **LIMITATION ON USE OF PREEXISTING CONDITION LIMITS.**—

(1) **INITIAL ISSURANCE.**—

(A) *IN GENERAL*.—Subject to subparagraph (B), a long-term care insurance policy may not exclude or condition benefits based on a medical condition for which the policyholder received treatment or was otherwise diagnosed before the issuance of the policy.

(B) *6-MONTH LIMIT*.—

(i) *IN GENERAL*.—No long-term care insurance policy or certificate issued under this part shall utilize a definition of “preexisting condition” that is more restrictive than the following: The term “preexisting condition” means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within 6 months preceding the effective date of coverage of an insured individual.

(ii) *PROHIBITION OF EXCLUSION OF COVERAGE*.—No long-term care insurance policy or certificate may exclude coverage for a loss or confinement that is the result of a preexisting condition unless such loss or confinement begins within 6 months following the effective date of the coverage of the insured individual.

(2) *REPLACEMENT POLICIES*.—If a long-term care insurance policy replaces another long-term care insurance policy, the issuer of the replacing policy shall waive any time periods applicable to preexisting conditions, waiting period, elimination periods and probationary periods in the new policy for similar benefits to the extent such time was spent under the original policy.

(f) *ELIGIBILITY FOR BENEFITS*.—

(1) *LONG-TERM CARE POLICIES*.—Each long-term care insurance policy shall—

(A) describe the level of benefit available under the policy; and

(B) specify in clear, understandable terms, the level (or levels) of physical, cognitive, or mental impairment required in order to receive benefits under the policy.

(2) *FUNCTIONAL ASSESSMENT*.—In order to submit a claim under any long-term care insurance policy, each claimant shall have a professional functional assessment of his or her functional or cognitive abilities. Such initial assessment shall be conducted by an individual or entity, meeting the qualifications established by the NAIC to assure the professional competence and credibility of such individual or entity and that such individual meets any applicable State licensure and certification requirements. The individual or entity conducting such assessment may not control, or be controlled by, the issuer of the policy. For purposes of this paragraph and paragraph (4), the term “control” means the direct or indirect possession of the power to direct the management and policies of a person. Control is presumed to exist, if any person directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing at least 10 percent of the voting securities of another person.

(3) *CLAIMS REVIEW*.—Except as provided in paragraph (1), each long-term care insurance policy shall be subject to final claims review by the carrier pursuant to the terms of the long-term care insurance policy.

(4) APPEALS PROCESS.—

(A) *IN GENERAL.*—Each long-term care insurance policy shall provide for a timely and independent appeals process, meeting standards established by the NAIC, for individuals who dispute the results of the claims review, conducted under paragraph (3), of the policyholder's functional assessment, conducted under paragraph (2).

(B) *INDEPENDENT ASSESSMENT.*—An appeals process under this paragraph shall include, at the request of the claimant, an independent assessment of the claimant's functional or cognitive abilities.

(C) *CONDUCT.*—An independent assessment under subparagraph (B) shall be conducted by an individual or entity meeting the qualifications established by the NAIC to assure the professional competence and credibility of such individual or entity and any applicable State licensure and certification requirements and may not be conducted—

(i) by an individual who has a direct or indirect significant or controlling interest in, or direct affiliation or relationship with, the issuer of the policy;

(ii) by an entity that provides services to the policyholder or certificate holder for which benefits are available under the long-term care insurance policy; or

(iii) by an individual or entity in control of, or controlled by, the issuer of the policy.

(5) *STANDARD ASSESSMENTS.*—Not later than 2 years after the date of enactment of this part, the advisory committee established under section 2701(a) shall recommend uniform needs assessments mechanisms for the determination of eligibility for benefits under such assessments.

(g) INFLATION PROTECTION.—

(1) *OPTION TO PURCHASE.*—A carrier may not offer a long-term care insurance policy unless the carrier also offers to the proposed policyholder, including each group policyholder, the option to purchase a policy that provides for increases in benefit levels, with benefit maximums or reasonable durations that are meaningful, to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. A carrier may not offer to a policyholder an inflation protection feature that is less favorable to the policyholder than one following:

(A) With respect to policies that provides for automatic periodic increases in benefits, the policy provides for an annual increase in benefits in a manner so that such increase are computed annually at a rate of not less than 5 percent.

(B) With respect to policies that provide for periodic opportunities to elect an increase in benefits, the policy guarantees that the insured individual will have the right to periodically increase the benefit levels under the policy without providing evidence of insurability or health status so long as the option for the previous period was not declined. The amount of any such additional benefit may not be less than the difference between—

(i) the existing policy benefit; and

(ii) such existing benefit compounded annually at a rate of at least 5 percent for the period beginning on the date on which the existing benefit is purchased and extending until the year in which the offer of increase is made.

(C) With respect to service benefit policies, the policy covers a specified percentage of the actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

(2) **EXCEPTION.**—The requirements of paragraph (1) shall not apply to life insurance policies or riders containing accelerated long-term care benefits.

(3) **REQUIRED INFORMATION.**—Carriers shall include the following information in or together with the outline of coverage provided under this part:

(A) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. Such comparison shall show benefit levels over not less than a 20-year period.

(B) Any expected premium increases or additional premiums required to pay for any automatic or optional benefit increases, whether the individual who purchases the policy obtains the inflation protection initially or whether such individual delays purchasing such protection until a future time.

(4) **CONTINUATION OF PROTECTION.**—Inflation protection benefit increases under this subsection under a policy that contains such protection shall continue without regard to an insured's age, claim status or claim history, or the length of time the individual has been insured under the policy.

(5) **CONSTANT PREMIUM.**—An offer of inflation protection under this subsection that provides for automatic benefit increases shall include an offer of a premium that the carrier expects to remain constant. Such offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

(6) **REJECTION.**—Inflation protection under this subsection shall be included in a long-term care insurance policy unless a carrier obtains a written rejection of such protection signed by the policyholder.

SEC. 2716. NONFORFEITURE.

(a) **IN GENERAL.**—Each long-term care insurance policy (or certificate) shall provide that if the policy lapses after the policy has been in effect for a minimum period (specified under the standards under section 2701(a)), the policy will provide, without payment of any additional premiums, nonforfeiture benefits as determined appropriate by the NAIC.

(b) **ESTABLISHMENT OF STANDARDS.**—The standards under section 2701(a) shall provide that the percentage or amount of benefits under subsection (a) must increase based upon the policyholder's equity in the policy.

SEC. 2717. LIMIT OF PERIOD OF CONTESTABILITY AND RIGHT TO RETURN.

(a) **CONTESTABILITY.**—A carrier may not cancel or renew a long-term care insurance policy or deny a claim under the policy based on fraud or intentional misrepresentation relating to the issuance of the policy unless notice of such fraud or misrepresentation is provided within a time period to be determined by the NAIC.

(b) **RIGHT TO RETURN.**—Each applicant for a long-term care insurance policy shall have the right to return the policy (or certificates) within 30 days of the date of its delivery (and to have the premium refunded) if, after examination of the policy or certificate, the applicant is not satisfied for any reason.

SEC. 2718. CIVIL MONEY PENALTY.

(a) **CARRIER.**—Any carrier, association or its subsidiary that sells or offers for sale a long-term care insurance policy and that—

(1) fails to make a refund in accordance with section 2713(a);

(2) fails to transmit a policy in accordance with section 2713(b);

(3) fails to provide, make available, or report information in accordance with subsections (c) or (d) of section 2713;

(4) provides a commission or compensation in violation of section 2713(e);

(5) fails to provide an outline of coverage in violation of section 2715(b)(1); or

(6) issues a policy without obtaining certain information in violation of section 2715(f);

is subject to a civil money penalty of not to exceed \$25,000 for each such violation.

(b) **AGENTS.**—Any agent that sells or offers for sale a long-term care insurance policy and that—

(1) fails to make a refund in accordance with section 2713(a);

(2) fails to transmit a policy in accordance with section 2713(b);

(3) fails to provide, make available, or report information in accordance with subsections (c) or (d) of section 2713;

(4) fails to provide an outline of coverage in violation of section 2715(b)(1); or

(5) issues a policy without obtaining certain information in violation of section 2715(f);

is subject to a civil money penalty of not to exceed \$15,000 for each such violation.

(c) **EFFECT ON STATE LAW.**—Nothing in this section shall be construed as preempting or otherwise limiting the penalties that may be imposed by a State for the types of conduct described in this section.

Subpart C—Long-Term Care Insurance Policies, Definition and Endorsements

SEC. 2721. LONG-TERM CARE INSURANCE POLICY DEFINED.

(a) **IN GENERAL.**—As used in this section, the term 'long-term care insurance policy' means any insurance policy, rider or certificate advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an ex-

pense incurred, indemnity prepaid or other basis, for one or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes—

(1) group and individual annuities and life insurance policies, riders or certificates that provide directly, or that supplement long-term care insurance; and

(2) a policy, rider or certificates that provides for payment of benefits based on cognitive impairment or the loss of functional capacity.

(b) **ISSUANCE.**—Long-term care policies may be issued by—

(1) carriers;

(2) fraternal benefit societies;

(3) nonprofit health, hospital, and medical service corporations;

(4) prepaid health plans;

(5) health maintenance organizations; or

(6) any similar organization to the extent they are otherwise authorized to issue life or health insurance.

(c) **POLICIES EXCLUDED.**—The term 'long-term care insurance policy' shall not include any insurance policy, rider or certificate that is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. With respect to life insurance, such term shall not include life insurance policies, riders or certificates that accelerate the death benefits specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

(d) **APPLICATIONS.**—Notwithstanding any other provision of this part, this part shall apply to any product advertised, marketed or offered as a long-term insurance policy, rider or certificate.

SEC. 2722. CODE OF CONDUCT WITH RESPECT TO ENDORSEMENTS.

Not later than 1 year after the date of enactment of this part the NAIC shall issue guidelines that shall apply to organizations and associations, other than employers and labor organizations that do not accept compensation, and their subsidiaries that provide endorsements of long-term care insurance policies, or that permit such policies to be offered for sale through the organization or association. Such guidelines shall include at minimum the following:

(1) In endorsing or selling long-term care insurance policies, the primary responsibility of an organization or association shall be to educate their members concerning such policies and assist such members in making informed decisions. Such organizations and associations may not function primarily as sales agents for insurance companies.

(2) Organizations and associations shall provide objective information regarding long-term care insurance policies sold or

endorsed by such organizations and associations to ensure that members of such organizations and associations have a balanced and complete understanding of both the strengths and weaknesses of the policies that are being endorsed or sold.

(3) Organizations and associations selling or endorsing long-term care insurance policies shall disclose in marketing literature provided to their members concerning such policies the manner in which such policies and the insurance company issuing such policies were selected. If the organization or association and the insurance company have interlocking directcrates, the organization or association shall disclose such fact to their members.

(4) Organizations and associations selling or endorsing long-term care insurance policies shall disclose in marketing literature provided to their members concerning such policies the nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support that the organization or association receives) for the endorsement or sale of the policy to its members.

(5) The Boards of Directors of organizations and associations selling or endorsing long-term care insurance policies, if such organizations and associations have a Board of Directors, shall review and approve such insurance policies, the compensation arrangements and the marketing materials used to promote sales of such policies.

PART 2—LIFE CARE: PUBLIC INSURANCE PROGRAM FOR NURSING HOME CARE

SEC. 2741. ESTABLISHMENT OF VOLUNTARY LONG-TERM CARE INSURANCE PROGRAM.

The Secretary shall establish a voluntary insurance program for individuals 35 years of age and over to cover the nursing home stays of such individuals. The Secretary shall establish a process for enrollment in the Life Care program.

SEC. 2742. BENEFITS.

(a) IN GENERAL.—

(1) **ELIGIBILITY FOR COVERAGE.**—Subject to subsection (c), an individual who meets the eligibility criteria prescribed in section 2743 shall be eligible under the program established under this part for coverage for necessary services described in subsection (b) (in the amounts described in subsection (c)) that are provided to the individual by a nursing facility while the individual is an inpatient of the facility.

(2) **NONFORFEITURE.**—The Secretary shall establish standards to ensure the nonforfeiture of benefits for which premiums have been paid.

(b) TYPES.—Coverage may be provided under this part for—

(1) nursing care provided by or under the supervision of a registered professional nurse;

(2) physical, occupational, or speech therapy furnished by a facility or by others under arrangements with a facility;

(3) medical social work services;

(4) drug, biological, supply, appliance, and equipment for use in the facility, that is ordinarily furnished by the facility for the care and treatment of an inpatient;

(5) such other services necessary to the functioning of a patient, including personal care and assistance with activities of daily living, as are generally provided by a nursing home facility; and

(6) with respect to the initial 6 months of covered residence in a nursing facility, such room and board costs as are not covered by beneficiary copayment.

(c) COVERAGE AMOUNT.—

(1) **IN GENERAL.**—The amount of coverage provided with respect to an eligible individual for the services described in subsection (b) shall, based on an election made by the individual, not exceed \$30,000, \$60,000, or \$90,000 over the lifetime of the eligible individual. Such amounts shall be adjusted by the Secretary to reflect increases in the Consumer Price Index.

(2) **ASSET PROTECTION.**—An eligible individual shall be entitled to the asset protection provided under section 2748.

(d) **PAYMENT.**—Amounts provided under this part with respect to an eligible individual for the services described in subsection (b) shall be paid from the general fund of the Treasury of the United States.

(e) **RESIDENTIAL CARE FACILITIES.**—The Secretary shall consider the feasibility of making payments under this part for services delivered in residential care facilities. Not later than 2 years after the date of enactment of this Act, the Secretary shall report its findings to the Congress with respect to the feasibility of making such payments.

SEC. 2743. ELIGIBILITY.

(a) **IN GENERAL.**—An individual shall be eligible for benefits under this part if—

(1) the individual—

(A) is a legal resident of the United States and has elected coverage under subsection (c);

(B) has been determined by a Screening Agency through a screening process (conducted in accordance with section 2747)—

(i)(I) to require hands-on or standby assistance, supervision, or cueing (as defined in regulations) to perform three or more activities of daily living; or

(II) to require hands-on or standby assistance, supervision, or cueing with at least such instrumental activity (or activities) of daily living related to cognitive or mental impairment as the Secretary specifies; or

(III) to display symptoms of one or more serious behavioral problems (that is on a list of such problems specified by the Secretary) which create a need for supervision to prevent harm to self or others; and

(ii) to require such assistance, supervision, or cueing over a period of at least 90 days; and

(C) has achieved a score, on a standard mental status protocol (or protocols) appropriate for measuring the individual's particular condition specified by the Secretary,

that indicates either severe cognitive impairment or severe mental impairment, or both; and

(2)(A) the individual has filed an application for such benefits, and is in need of, benefits covered under this part; or

(B) the legal guardian of the individual has filed an application on behalf of an individual who is in need of benefits covered under this part;

(C) the representative of an individual who is cognitively impaired and who is in need of benefits covered under this part has filed an application on behalf of the individual.

(b) **CURRENT INDIVIDUALS.**—An individual who is in a hospital or nursing home on the date of the enrollment of the individual in the program established under this part shall be ineligible for coverage under this section until the individual's first spell of illness beginning after such date.

(c) **ELECTION OF COVERAGE.**—

(1) **IN GENERAL.**—Subject to this subsection, an individual shall have the option to purchase coverage under this part when the individual is 35 years of age, 45 years of age, 55 years of age, or 65 years of age.

(2) **INITIAL YEAR.**—During the 1-year period beginning on the date on which final regulations that implement this part are issued, an individual who is 35 years of age or older shall be eligible to purchase insurance under this part, except that such an individual shall not be eligible to purchase such insurance—

(A) while confined to a hospital or nursing home;

(B) within the 6-month period after the individual's confinement in a nursing home; or

(C) within the 90-day period after the individual's confinement in a hospital.

Individuals described in the matter preceding subparagraph (A) shall become eligible to receive benefits under this part on the expiration of the 3-year period beginning on the date such individuals purchase insurance under this part.

(3) **EXTENSION BEYOND INITIAL YEAR.**—If an individual is confined to a nursing home or hospital during a period that extends beyond the first year after the effective date of this part, an individual shall be eligible to enroll in the program established by this part during the 60-day period beginning after the individual's spell of illness.

(4) **SUBSEQUENT YEARS.**—During years subsequent to the 1-year period referred to in paragraph (2), an individual shall be eligible to purchase insurance under this part within 6 months of the 35th, 45th, 55th, or 65th birthday of the individual.

(5) **ACTIVATION OF BENEFITS.**—To receive coverage under the insurance program established by this part, an individual shall have purchased such coverage not later than 1 month prior to admission to a nursing facility, unless the reason for the need of services is a result of an accident or stroke subsequent to the date that such individual enrolled for coverage under this part.

(d) **PUBLIC EDUCATION.**—In the 12 months preceding the initial enrollment period, the Secretary shall, either directly or through grants and contracts, conduct a public service and education campaign designed to inform potentially eligible individuals as to the

nature of the benefits and the limited enrollment period. In conducting such campaigns the Secretary shall make information available to individuals through the open enrollment process for obtaining health care benefits under this Act.

SEC. 2744. PREMIUM RATES.

(a) *IN GENERAL.*—The Secretary shall determine one premium rate for individuals electing to purchase coverage under this part at age 35 (or between the ages of 35 and 44 during the initial enrollment period), a separate rate for those individuals who elect coverage at age 45 (or between the ages of 45 and 54 during the initial enrollment period), a separate rate for those individuals who elect such coverage at age 55 (or between the ages of 55 and 64 during the initial enrollment period), and a separate rate for those individuals who elect such coverage at age 65 (or at age 65 and over during the initial enrollment period). During the initial enrollment period, the Secretary shall establish actuarially fair, age-related premiums for persons age 65 and over.

(b) *REVISION.*—The Secretary shall revise premium rates annually to increase such rates to reflect the amount of the increase in the cost of living adjustment with respect to benefits under title II of the Social Security Act.

(c) *RATES.*—In developing premium rates under the program established under this part, the Secretary shall establish rates that are expected to cover 100 percent of the reimbursement amount provided under this part for nursing home stays for those individuals enrolled in the program.

(d) *WAIVER.*—An individual electing to purchase coverage under this part shall not be required to pay premiums during any period in which such individual is receiving benefits under this part.

(e) *PAYMENT.*—Premiums shall be paid under this section into the general fund of the Treasury of the United States.

SEC. 2745. QUALIFIED SERVICE PROVIDERS.

(a) *IN GENERAL.*—To be considered as a covered nursing home service under this part, such service must have been provided by a qualified service provider.

(b) *TYPES.*—A provider shall be considered a qualified service provider under this part if the provider is a nursing facility that is certified by the State and meets the requirements of this part and any other standards established by the Secretary by regulation for the safe and efficient provision of services covered under this part.

SEC. 2746. REIMBURSEMENT.

(a) *AMOUNT.*—Monthly reimbursement for nursing facility services under this part shall equal 65 percent (or during the initial 6 months of coverage, 80 percent) of the amount the Secretary determines to be reasonable and appropriate to cover the cost of care provided under this part.

(b) *PROSPECTIVE PAYMENT.*—To the extent feasible, the Secretary shall establish a prospective payment mechanism for payment for nursing home services under this part that takes into account the expected resource utilization of individual patients based on their degree of disability, the methodology recommended for reimbursement of skilled nursing facilities under title XVIII of the Social Security Act, and other factors determining service requirements.

(c) **ROOM AND BOARD PAYMENT.**—An individual receiving benefits under this program shall be responsible for the payment of an amount for room and board that is equal to—

(1) with respect to the initial 6 months of residence in a nursing facility, 20 percent of the average per diem rate paid by the Secretary to nursing facilities receiving reimbursement under this part; and

(2) with respect to subsequent periods of residence, 35 percent of the average per diem rate paid by the Secretary to nursing facilities receiving reimbursement under this part. Payments under subsection (a) and (c) shall be considered payment in full for services received under this section.

(d) **PRIORITY PAYERS.**—Notwithstanding any other provision of this part, reimbursement for nursing facility services provided under this part to an individual shall, to the extent available, be made under the Medicare program, under Department of Veterans Affairs' programs, or under private insurance policies prior to reimbursement under this part.

SEC. 2747. LONG-TERM CARE SCREENING AGENCY.

(a) **ESTABLISHMENT.**—The Secretary shall contract with entities to act as Long-Term Care Screening Agencies (hereafter referred to in this part as the "Screening Agency") for each designated area of a State. It shall be the responsibility of such agency to assess the eligibility of individuals residing in the geographic jurisdiction of the Agency, for services provided under this part according to the requirements of this part and regulations prescribed by the Secretary. In entering into such contracts, the Secretary shall give preference to State governmental entities and private nonprofit agencies.

(b) **ELIGIBILITY.**—The Screening Agency shall determine the eligibility of an individual under this part based on the results of a preliminary telephone interview or written questionnaire (completed by the applicant, by the caregiver of the applicant, or by the legal guardian or representative of the applicant) that shall be validated through the use of a screening tool administered in person to each applicant determined eligible through initial telephone or written questionnaire interviews not later than 15 days from the date on which such individual initially applied for services under this part.

(c) **QUESTIONNAIRES AND SCREENING TOOLS.**—

(1) **IN GENERAL.**—The Secretary shall establish a telephone or written questionnaire and a screening tool to be used by the Screening Agency to determine the eligibility of an individual for services under this part consistent with requirements of this part and the standards established by the Secretary by regulation.

(2) **QUESTIONNAIRES.**—The questionnaire shall include questions about the functional impairment and mental status of an individual and other criteria that the Secretary shall prescribe by regulation.

(3) **SCREENING TOOLS.**—The screening tool should measure functional impairment caused by physical or cognitive conditions as well as information concerning cognition disability, behavioral problems (such as wandering or abusive and aggressive behavior), and any other criteria that the Secretary shall

prescribe by regulation. The screening tool shall be administered in person.

(d) **NOTIFICATION.**—Not later than 15 days after the date on which an individual initially applied for services under this part (by telephone or written questionnaire), the Screening Agency shall notify such individual that such individual is not eligible for benefits, or that such individuals must schedule an in-person screening to determine final eligibility for benefits under this part. The Screening Agency shall notify such individual of its final decision no later than 2 working days after the in-person screening.

(e) **IN-PERSON SCREENING.**—An individual (or the legal guardian or representative of such individual) whose application for benefits under this part is denied on the basis of information provided through a telephone or written questionnaire, shall be notified of such individual's right to an in-person screening by a nurse or appropriate health care professionals.

(f) **APPEALS.**—The Secretary shall establish a mechanism for hearings and appeals in cases in which individuals contest the eligibility findings of the Screening Agency.

(g) **PAYMENT.**—

(1) **PAYMENT FOR SCREENING.**—The Screening Agency may require payment from individuals only in accordance with standards established by the Secretary.

(2) **NO PAYMENT FOR POOREST.**—The Screening Agency may not require payment for individuals with incomes of less than 150 percent of the official poverty line.

SEC. 2748. ASSET PROTECTION.

Notwithstanding any other provision of law, the assets an eligible individual may retain and be determined eligible for nursing facility benefits, including payments of room and board under this part, under State Medicaid programs (in accordance with section 1902(a)(10)) shall be increased by the amount of coverage (\$30,000, \$60,000, or \$90,000) elected under section 2742.

SEC. 2749. RELATION TO PRIVATE INSURANCE.

(a) **IN GENERAL.**—Except as provided in subsection (b), an insurer may not offer a long-term care insurance policy to an individual who has purchased coverage under this part if the coverage under such policy duplicates the coverage provided under this part.

(b) **DEVELOPMENT OF STANDARD PACKAGES.**—The Secretary shall develop standard long-term care insurance benefits packages that insurers may offer to insured individuals under this part. Such packages shall provide coverage for benefits that complement, but do not duplicate, those covered under this part.

SEC. 2750. DEFINITIONS.

As used in this part:

(1) **NURSING FACILITY.**—The term “nursing facility” means—

(A) a skilled nursing facility (as defined in section 1819(a) of the Social Security Act); or

(B) a facility that is a nursing facility (as defined in section 1919(a) of such Act) which meets the requirements of section 1819(b)(4)(C) of such Act (relating to nursing care).

(2) **SPELL OF ILLNESS.**—The term “spell of illness” means a period of consecutive days beginning with the first day on

which an individual is furnished services as an inpatient in a hospital or nursing facility and ending with the close of the first 6 consecutive months thereafter during which the individual is no longer an inpatient of a nursing facility, or 90 days after the individual is no longer an inpatient in a hospital.

SEC. 2751. REPORTS.

(a) *IN GENERAL.*—Prior to the promulgation of regulations implementing this title, the Secretary shall report to Congress on—

(1) the actuarially-sound premium rates to be used in the implementation of this Act, including whether the premiums will cover 100 percent of the benefits paid out, and whether Federal funds will be required to support the payment of benefits;

(2) an assessment of the impact of such premium rates on the affordability of coverage under this Act;

(3) a projected enrollment of individuals by age category; and

(4) an estimate of current and projected enrollment of individuals, by age category in coverage under private long-term care insurance.

(b) *LIFE CARE REPORT.*—Not later than 2 years after the promulgation of regulations implementing this title, the Secretary shall report to Congress on the following aspects of the Life Care Act:

(1) The current and projected premium rates.

(2) The current and projected enrollment of individuals, by age category and an estimate of current and projected enrollment of individuals by age category in private long-term care insurance.

(3) The projected use of benefits and the impact of use on premium rates.

(4) An assessment of the impact of projected premium rates on the affordability of coverage under this Act.

(c) *RECOMMENDATIONS.*—The Secretary shall make recommendations to Congress regarding necessary revisions to the Life Care Act as a result of the findings provided in the reports submitted under this section.

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EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

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PART 6—CONTINUATION COVERAGE UNDER GROUP HEALTH PLANS

[Sec. 601. Plans must provide continuation coverage to certain individuals.]

Sec. 601. Additional standards for group health plans.

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DEFINITIONS

SEC. 3. [1002] For purposes of this title:

(1) * * *

* * * * *

[(40)(A) The term "multiple employer welfare arrangement" means an employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan), which is established or maintained for the purpose of offering or providing any benefit described in paragraph (1) to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that such term does not include any such plan or other arrangement which is established or maintained—

[(i) under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements,

[(ii) by a rural electric cooperative, [or]

[(iii) by a rural telephone cooperative association[.], or

[(iv) by a regional alliance (as defined in section 1301 of the Health Security Act).

[(B) For purposes of this paragraph—

[(i) two or more trades or businesses, whether or not incorporated, shall be deemed a single employer if such trades or businesses are within the same control group,

[(ii) the term "control group" means a group of trades or businesses under common control,

[(iii) the determination of whether a trade or business is under "common control" with another trade or business shall be determined under regulations of the Secretary applying principles similar to the principles applied in determining whether employees of two or more trades or businesses are treated as employed by a single employer under section 4001(b), except that, for purposes of this paragraph, common control shall not be based on an interest of less than 25 percent,

[(iv) the term "rural electric cooperative" means—

[(I) any organization which is exempt from tax under section 501(a) of the Internal Revenue Code of 1986 and which is engaged primarily in providing electric service on a mutual or cooperative basis; and

[(II) any organization described in paragraph (4) or (6) of section 501(c) of the Internal Revenue Code of 1986 which is exempt from tax under section 501(a) of such Code and at least 80 percent of the members of which are organizations described in subclause (I), and

[(v) the term "rural telephone cooperative association" means an organization described in paragraph (4) or (6) of section 501(c) of the Internal Revenue Code of 1986 which is exempt from tax under section 501(a) of such Code and at least 80 percent of the members of which are organizations engaged primarily in providing telephone service to rural areas of the United States on a mutual, cooperative, or other basis.]

* * * * *

(42) The term “group health plan” means an employee welfare benefit plan which provides medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise.

* * * * *

COVERAGE

SEC. 4. [1003] (a) Except as provided in [subsection (b)] subsections (b) and (c) and in sections 201, 301, and 401, this title shall apply to any employee benefit plan if it is established or maintained—

* * * * *

(b) [The provisions] *Except as provided in subsection (c), the provisions of this title shall not apply to any employee benefit plan if—*

(c) *COVERAGE OF GROUP HEALTH PLANS.—*

(1) *LIMITED INCLUSION.—This title shall apply to a group health plan only to the extent provided in this subsection.*

(2) *COVERAGE UNDER CERTAIN PROVISIONS WITH RESPECT TO CERTAIN PLANS.—*

(A) *IN GENERAL.—Except as provided in subparagraph*

(B) *and parts 1, 4, 5, and 6 of subtitle B shall apply to—*

(i) *a group health plan which is maintained by—*

(I) *a large group purchaser (as defined in section 1311(a) of the Health Security Act), or*

(II) *a member of a large group purchaser (as so defined) whose eligible sponsor is described in section 1311(b)(1)(C) (relating to rural electric cooperatives and rural telephone cooperative associations), and*

(ii) *a group health plan not described in clause (i) which provides benefits which are permitted under paragraph (4) of section 1003 of the Health Security Act.*

(B) *SUPPLEMENTAL PLANS.—The Secretary shall provide by regulation for treatment as a separate group health plan of any arrangement which would otherwise be treated under this title as part of a group health plan to the extent necessary to carry out the purposes of this title.*

(3) *CIVIL ACTIONS.—Section 502(a)(1)(B) of this Act (with respect to the cause of action for the recovery of benefits) shall not apply to action by participants, beneficiaries and fiduciaries governed under subtitle C of title V of the Health Security Act.*

(4) *DEFINITIONS AND ENFORCEMENT PROVISIONS.—Sections 3, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, and 511 and the preceding subsections of this section shall apply to a group health plan to the extent necessary to effectively carry out, and enforce the requirements under, the provisions of this title as they apply pursuant to this subsection.*

(5) *APPLICABILITY OF PREEMPTION RULES.*—Section 514 shall apply in the case of any group health plan to which parts 1, 4, and 6 of subtitle B apply under paragraph (2).

* * * * *

ALTERNATIVE METHODS OF COMPLIANCE BY PENSION PLANS

SEC. 110. [1030] (a) * * *

* * * * *

SPECIAL RULES FOR GROUP HEALTH PLANS

SEC. 111. *IN GENERAL.*—The Secretary shall by regulation provide special rules for the application of this part to group health plans which are consistent with the purposes of this title and the Health Security Act and which take into account the special needs of participants, beneficiaries, and health care providers under such plans.

(b) *EXPEDITIOUS REPORTING AND DISCLOSURE.*—Such special rules may include rules providing for—

(1) reductions in the periods of time referred to in this part,

(2) increases in the frequency of reports and disclosures required under this part, and

(3) such other changes in the provisions of this part as may result in more expeditious reporting and disclosure of plan terms and changes in such terms to the Secretary and to plan participants and beneficiaries,

to the extent that the Secretary determines that the rules described in this subsection are necessary to ensure timely reporting and disclosure of information consistent with the purposes of this part and the Health Security Act as they relate to group health plans.

(c) *ADDITIONAL REQUIREMENTS.*—Such special rules may include rules providing for reporting and disclosure to the Secretary and to participants and beneficiaries of additional information or at additional times with respect to group health plans to which this part applies under section , if such reporting and disclosure would be comparable to and consistent with similar requirements applicable under the Health Security Act with respect to community-rated employer plans and applicable regulations of the Secretary of Health and Human Services prescribed thereunder.

* * * * *

REPEAL AND EFFECTIVE DATE

[SEC. 111] SEC. 112. [1031] (a)(1) * * *

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CIVIL ENFORCEMENT

SEC. 502. [1132] (a) A civil action may be brought—

(1) * * *

* * * * *

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section [609(a)(2)(A)] 601(a)(2)(A)); or

* * * * *

(c)(1) Any administrator (A) who fails to meet the requirements of [paragraph (1) or (4) of section 606] or section 101(e)(1) with respect to a participant or beneficiary, or (B) who fails or refuses to comply with a request for any information which such administrator is required by this title to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to \$100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper.

CLAIMS PROCEDURE

SEC. 503. (a) *IN GENERAL.*— [1133] In accordance with regulations of the Secretary, every employee benefit plan shall—

* * * * *

(b) *GROUP HEALTH PLANS.*—*In addition to the requirements of subsection (a), of group health plan to which parts 1 and 4 apply under section 4(c)(2) shall comply with the requirements of section 5201 of the Health Security Act (relating to health plan claims procedures).*

* * * * *

EFFECT ON OTHER LAWS

SEC. 514. [1144] (a) * * *

* * * * *

(b)(1) * * *

* * * * *

(2)(A) Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance *State-certified health plans (as defined in section 1500 of the Health Security Act of 1994)*, banking, or securities.

(B) Neither an employee benefit plan described in section 4(a), which is not exempt under section 4(b) (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or *State-certified health plan*, other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

* * * * *

[(5)(A) Except as provided in subparagraph (B), subsection (a) shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 393-1 through 393-51).

[(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a)—

[(i) any State tax law relating to employee benefit plans, or

[(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

[(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after the date of the enactment of this paragraph [January 14, 1983]), but the Secretary may enter into cooperative arrangements under this paragraph and section 506 with officials of the State of Hawaii to assist them in effectuating the policies of provisions of such Act which are superseded by such parts 1 and 4 and the preceding sections of this part.]

(5)(A) *Except as provided in subparagraphs (B) and (C), subsection (a) shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 393-1 through 393-51).*

(B) *Nothing in subparagraph (A) shall be construed to exempt from subsection (a) any State tax law relating to employee benefits plans.*

(C) *If the Secretary of Labor notifies the Governor of the State of Hawaii that as the result of an amendment to the Hawaii Prepaid Health Care Act enacted after the date of the enactment of this paragraph—*

(i) the proportion of the population with health care coverage under such Act is less than such proportion on such date, or

(ii) the level of benefit coverage provided under such Act is less than the actuarial equivalent of such level of coverage on such date,

subparagraph (A) shall not apply with respect to the application of such amendment to such Act after the date of such notification.”

* * * * *

[(6)(A) Notwithstanding any other provision of this section—

[(i) in the case of an employee welfare plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides—

[(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

[(II) provisions to enforce such standards, and

[(ii) in the case of any other employee welfare plan which is a multiple employer welfare arrangement, in addition to this title, any law of any State which regulates insurance may

apply to the extent not inconsistent with the preceding sections of this title.

[(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 3(l) and section 4 necessary to be considered an employee welfare benefit plan to which this title applies.

[(C) Nothing in subparagraph (A) shall affect the manner of extent to which the provisions of this title apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries.

[(D) For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.]

* * * * *

(8) Subsection (a) of this section shall not be construed to preclude any State cause of action—

(A) with respect to which the State exercises its acquired rights under section [609] 601(b)(3) with respect to a group health plan (as defined in section 607(1)), or

* * * * *

[SEC. 601. [1161] PLANS MUST PROVIDE CONTINUATION COVERAGE TO CERTAIN INDIVIDUALS.

[(a) IN GENERAL.—The plan sponsor of each group health plan shall provide, in accordance with this part, that each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event is entitled, under the plan, to elect, within the election period, continuation coverage under the plan.

[(b) EXCEPTION FOR CERTAIN PLANS.—Subsection (a) shall not apply to any group health plan for any calendar year if all employers maintaining such plan normally employed fewer than 20 employees on a typical business day during the preceding calendar year.

[SEC. 602. [1162] CONTINUATION COVERAGE.

[For purposes of section 601, the term “continuation coverage” means coverage under the plan which meets the following requirements:

[(1) TYPE OF BENEFIT COVERAGE.—The coverage must consist of coverage which, as of the time the coverage is being provided, is identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred. If coverage is modi-

fied under the plan for any group of similarly situated beneficiaries, such coverage shall also be modified in the same manner for all individuals who are qualified beneficiaries under the plan pursuant to this part in connection with such group.

[(2) PERIOD OF COVERAGE.—The coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:

[(A) MAXIMUM REQUIRED PERIOD.—

[(i) GENERAL RULE FOR TERMINATIONS AND REDUCED HOURS.—In the case of a qualifying event described in section 603(2), except as provided in clause (ii), the date which is 18 months after the date of the qualifying event.

[(ii) SPECIAL RULE FOR MULTIPLE QUALIFYING EVENTS.—If a qualifying event (other than a qualifying event described in section 603(6)) occurs during the 18 months after the date of a qualifying event described in section 603(2), the date which is 36 months after the date of the qualifying event described in section 603(2).

[(iii) SPECIAL RULE FOR CERTAIN BANKRUPTCY PROCEEDINGS.—In the case of a qualifying event described in section 603(6) (relating to bankruptcy proceedings), the date of the death of the covered employee or qualified beneficiary (described in section 607(3)(C)(iii)), or in the case of the surviving spouse or dependent children of the covered employee, 36 months after the date of the death of the covered employee.

[(iv) GENERAL RULE FOR OTHER QUALIFYING EVENTS.—In the case of a qualifying event not described in section 603(2) or 603(6), the date which is 36 months after the date of the qualifying event.

[(v) QUALIFYING EVENT INVOLVING MEDICARE ENTITLEMENT.—In the case of an event described in section 603(4) (without regard to whether such event is a qualifying event), the period of coverage for qualified beneficiaries other than the covered employee for such event or any subsequent qualifying event shall not terminate before the close of the 36-month period beginning on the date the covered employee becomes entitled to benefits under title XVIII of the Social Security Act.

In the case of an individual who is determined, under title II or XVI of the Social Security Act, to have been disabled at the time of a qualifying event described in section 603(2), any reference in clause (i) or (ii) to 18 months with respect to such event is deemed a reference to 29 months, but only if the qualified beneficiary has provided notice of such determination under section 606(3) before the end of such 18 months.

[(B) END OF PLAN.—The date on which the employer ceases to provide any group health plan to any employee.

[(C) FAILURE TO PAY PREMIUM.—The date on which coverage ceases under the plan by reason of a failure to make

timely payment of any premium required under the plan with respect to the qualified beneficiary. The payment of any premium (other than any payment referred to in the last sentence of paragraph (3)) shall be considered to be timely if made within 30 days after the date due or within such longer period as applies to or under the plan.

[(D) GROUP HEALTH PLAN COVERAGE] OR MEDICARE ENTITLEMENT, *MEDICARE ENTITLEMENT, OR QUALIFIED HEALTH PLAN ELIGIBILITY.*—The date on which the qualified beneficiary first becomes, after the date of the election—

[(i) covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary, [or]

[(ii) in the case of a qualified beneficiary other than a qualified beneficiary described in section 607(3)(C), entitled to benefits under title XVIII of the Social Security Act], or

[(iii) *eligible for coverage under a qualified health plan in accordance with title I of the Health Security Act.*

An individual whose employment has been terminated by an employer offering health plans through a large group must elect within 30 days of the termination to either remain in the plan provided by the employer for a period of not to exceed 12 months or until the individual is reemployed, whichever is less, or purchase from another plan in the marketplace.

[(E) TERMINATION OF EXTENDED COVERAGE FOR DISABILITY.—In the case of a qualified beneficiary who is disabled at the time of a qualifying event described in section 603(2), the month that begins more than 30 days after the date of the final determination under title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled.

[(3) PREMIUM REQUIREMENTS.—The plan may require payment of a premium for any period of continuation coverage, except that such premium—

[(A) shall not exceed 102 percent of the applicable premium for such period, and

[(B) may, at the election of the payor, be made in monthly installments.

In no event may the plan require the payment of any premium before the day which is 45 days after the day on which the qualified beneficiary made the initial election for continuation coverage. In the case of an individual described in the last sentence of paragraph (2)(A), any reference in subparagraph (A) of this paragraph to “102 percent” is deemed a reference to “150 percent” for any month after the 18th month of continuation coverage described in clause (i) or (ii) of paragraph (2)(A).

[(4) NO REQUIREMENT OF INSURABILITY.—The coverage may not be conditioned upon, or discriminate on the basis of lack of, evidence of insurability.

[(5) CONVERSION OPTION.—In the case of a qualified beneficiary whose period of continuation coverage expires

under paragraph (2)(A), the plan must, during the 180-day period ending on such expiration date, provide to the qualified beneficiary the option of enrollment under a conversion health plan otherwise generally available under the plan.

SEC. 603. [1163] QUALIFYING EVENT.

[For purposes of this part, the term "qualifying event" means, with respect to any covered employee, any of the following events which, but for the continuation coverage required under this part, would result in the loss of coverage of a qualified beneficiary:

[(1) The death of the covered employee.

[(2) The termination (other than by reason of such employee's gross misconduct), or education of hours, of the covered employee's employment.

[(3) The divorce or legal separation of the covered employee from the employee's spouse.

[(4) The covered employee becoming entitled to benefits under title XVIII of the Social Security Act.

[(5) A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan.

[(6) A proceeding in a case under title 11, United States Code, commencing on or after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time.

In the case of an event described in paragraph (6), a loss of coverage includes a substantial elimination of coverage with respect to a qualified beneficiary described in section 607(3)(C) within one year before or after the date of commencement of the proceeding.

SEC. 604. [1164] APPLICABLE PREMIUM.

[For purposes of this part—

[(1) **IN GENERAL.**—The term "applicable premium" means, with respect to any period of continuation coverage of qualified beneficiaries, the cost to the plan for such period of the coverage for similarly situated beneficiaries with respect to whom a qualifying event has not occurred (without regard to whether such cost is paid by the employer or employee).

[(2) **SPECIAL RULE FOR SELF-INSURED PLANS.**—To the extent that a plan is a self-insured plan—

[(A) **IN GENERAL.**—Except as provided in subparagraph (B), the applicable premium for any period of continuation coverage of qualified beneficiaries shall be equal to a reasonable estimate of the cost of providing coverage for such period for similarly situated beneficiaries which—

[(i) is determined on an actuarial basis, and

[(ii) takes into account such factors as the Secretary may prescribe in regulations.

[(B) **DETERMINATION ON BASIS OF PAST COST.**—If an administrator elects to have this subparagraph apply, the applicable premium for any period of continuation coverage of qualified beneficiaries shall be equal to—

[(i) the cost to the plan for similarly situated beneficiaries for the same period occurring during the pre-

ceding determination period under paragraph (3), adjusted by

[(ii) the percentage increase or decrease in the implicit price deflator of the gross national product (calculated by the Department of Commerce and published in the Survey of Current Business) for the 12-month period ending on the last day of the sixth month of such preceding determination period.

[(C) SUBPARAGRAPH (B) NOT TO APPLY WHERE SIGNIFICANT CHANGE.—An administrator may not elect to have subparagraph (B) apply in any case in which there is any significant difference, between the determination period and the preceding determination period, in coverage under, or in employees covered by, the plan. The determination under the preceding sentence for any determination period shall be made at the same time as the determination under paragraph (3).

[(3) DETERMINATION PERIOD.—The determination of any applicable premium shall be made for a period of 12 months and shall be made before the beginning of such period.

SEC. 605. [1165] ELECTION.

[For purposes of this part—

[(1) ELECTION PERIOD.—The term “election period” means the period which—

[(A) begins not later than the date on which coverage terminates under the plan by reason of a qualifying event,

[(B) is of at least 60 days’ duration, and

[(C) ends not earlier than 60 days after the later of—

[(i) the date described in subparagraph (A), or

[(ii) in the case of any qualified beneficiary who receives notice under section 606(4), the date of such notice.

[(2) EFFECT OF ELECTION ON OTHER BENEFICIARIES.—Except as otherwise specified in an election, any election of continuation coverage by a qualified beneficiary described in subparagraph (A)(i) or (B) of section 607(3) shall be deemed to include an election of continuation coverage on behalf of any other qualified beneficiary who would lose coverage under the plan by reason of the qualifying event. If there is a choice among types of coverage under the plan, each qualified beneficiary is entitled to make a separate selection among such types of coverage.

SEC. 606. [1166] NOTICE REQUIREMENTS.

[(a) IN GENERAL.—In accordance with regulations prescribed by the Secretary—

[(1) the group health plan shall provide, at the time of commencement of coverage under the plan, written notice to each covered employee and spouse of the employee (if any) of the rights provided under this subsection,

[(2) the employer of an employee under a plan must notify the administrator of a qualifying event described in paragraph (1), (2), (4), or (6) of section 603 within 30 days (or, in the case of a group health plan which is a multiemployer plan, such

longer period of time as may be provided in the terms of the plan) of the date of the qualifying event.

[(3) each covered employee or qualified beneficiary is responsible for notifying the administrator of the occurrence of any qualifying event described in paragraph (3) or (5) of section 603 within 60 days after the date of the qualifying event and each qualified beneficiary who is determined, under title II or XVI of the Social Security Act, to have been disabled at the time of a qualifying event described in section 603(2) is responsible for notifying the plan administrator of such determination within 60 days after the date of the determination and for notifying the plan administrator within 30 days after the date of any final determination under such title or titles that the qualified beneficiary is no longer disabled, and

[(4) the administrator shall notify—

[(A) in the case of a qualifying event described in paragraph (1), (2), (4), or (6) of section 603, any qualified beneficiary with respect to such event, and

[(B) in the case of a qualifying event described in paragraph (3) or (5) of section 603 where the covered employee notifies the administrator under paragraph (3), any qualified beneficiary with respect to such event,

of such beneficiary's rights under this section.

[(b) ALTERNATIVE MEANS OF COMPLIANCE WITH REQUIREMENT FOR NOTIFICATION OF MULTIEMPLOYER PLANS BY EMPLOYERS.—The requirements of subsection (a)(2) shall be considered satisfied in the case of a multiemployer plan in connection with a qualifying event described in paragraph (2) of section 603 if the plan provides that the determination of the occurrence of such qualifying event will be made by the plan administrator.

[(c) RULES RELATING TO NOTIFICATION OF QUALIFIED BENEFICIARIES BY PLAN ADMINISTRATOR—For purposes of subsection (a)(4), any notification shall be made within 14 days (or, in the case of a group health plan which is a multiemployer plan, such longer period of time as may be provided in the terms of the plan) of the date on which the administrator is notified under paragraph (2) or (3), whichever is applicable, and any such notification to an individual who is a qualified beneficiary as the spouse of the covered employee shall be treated as notification to all other qualified beneficiaries residing with such spouse at the time such notification is made.

SEC. 607. [1167] DEFINITION AND SPECIAL RULES.

[For purposes of this part—

[(1) GROUP HEALTH PLAN.—The term “group health plan” means an employee welfare benefit plan providing medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise.

[(2) COVERED EMPLOYEE.—The term “covered employee” means an individual who is (or was) provided coverage under a group health plan by virtue of the performance of services by the individual for 1 or more persons maintaining the plan (including as an employee defined in section 401(c)(1) of the Internal Revenue Code of 1986).

[(3) QUALIFIED BENEFICIARY.—

[(A) IN GENERAL.—The term “qualified beneficiary” means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan—

[(i) as the spouse of the covered employee, or

[(ii) as the dependent child of the employee.

[(B) SPECIAL RULE FOR TERMINATIONS AND REDUCED EMPLOYMENT.—In the case of a qualifying event described in section 603(2), the term “qualified beneficiary” includes the covered employee.

[(C) SPECIAL RULE FOR RETIREES AND WIDOWS.—In the case of a qualifying event described in section 603(6), the term “qualified beneficiary” includes a covered employee who had retired on or before the date of substantial elimination of coverage and any other individual who, on the day before such qualifying event, is a beneficiary under the plan—

[(i) as the spouse of the covered employee,

[(ii) as the dependent child of the employee, or

[(iii) as the surviving spouse of the covered employee.

[(D) SPECIAL RULE FOR INDIVIDUALS COVERED BY HEALTH SECURITY ACT.—*The term “qualified beneficiary” shall not include any individual who, upon termination of coverage under a group health plan, is eligible for coverage under a comprehensive benefit package described in section 1101 of the Health Security Act.*

[(4) EMPLOYER.—Subsection (n) (relating to leased employees) and subsection (t) (relating to application of controlled group rules to certain employee benefits) of section 414 of the Internal Revenue Code of 1986 shall apply for purposes of this part in the same manner and to the same extent as such subsections apply for purposes of section 106 of such Code. Any regulations prescribed by the Secretary pursuant to the preceding sentence shall be consistent and coextensive with any regulation prescribed for similar purposes by the Secretary of the Treasury (or such Secretary’s delegate) under such subsections.

[(5) OPTIONAL EXTENSION OF REQUIRED PERIODS.—A group health plan shall not be treated as failing to meet the requirements of this part solely because the plan provides both—

[(A) that the period of extended coverage referred to in section 602(2) commences with the date of loss of coverage, and

[(B) that the applicable notice period provided under section 606(a)(2) commences with the date of the loss of coverage.

SEC. 608. [1168] REGULATIONS.

[The Secretary may prescribe regulations to carry out the provisions of this part.]

PART 6—GROUP HEALTH PLANS

GROUP HEALTH PLANS

ADDITIONAL STANDARDS FOR GROUP HEALTH PLANS

SEC. 609. [601.] (a) Group Health Plan Coverage Pursuant to Medical Child Support Orders.—

(1) * * *

* * * *

(A) * * *

* * * *

(ii) enforces a law relating to medical child support described in section 1908 of the Social Security Act (as added by [section 13822] *section 13623* of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health plan.

* * * *

(4) RESTRICTION ON NEW TYPES OR FORMS OF BENEFITS.—A medical child support order meets the requirements of this paragraph only if such order does not require a plan to provide any type or form of benefit, or any option, not otherwise provided under the plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in section 1908 of the Social Security Act (as added by section [13822] *section 13623* of the Omnibus Budget Reconciliation Act of 1993).

* * * *

(4) REGULATIONS BY NATIONAL HEALTH BOARD.—*The preceding provisions of this subsection shall apply except to the extent otherwise provided in regulations of the National Health Board under the Health Security Act.*

(d) CONTINUED COVERAGE OF COSTS OF A PEDIATRIC VACCINE UNDER GROUP HEALTH PLANS.—A group health plan may not reduce its coverage of the costs of pediatric vaccines (as defined under section 1928(h)(6) of the Social Security Act as amended by [section 13830] *section 13631* of the Omnibus Budget Reconciliation Act of 1993) below the coverage it provided as of May 1, 1993. *The preceding sentence shall cease to apply to a group health plan upon becoming a corporate alliance health plan pursuant to an effective election of the plan sponsor to be a corporate alliance under section 1311 of the Health Security Act."*

(e) REGULATIONS.—Any regulations prescribed under this section shall be prescribed by the Secretary of Labor, in consultation with the Secretary of Health and Human Services.

* * * *

CHILD NUTRITION ACT OF 1966

* * * *

SEC. 1786. SPECIAL SUPPLEMENTAL FOOD PROGRAM.

(a) CONGRESSIONAL FINDINGS AND DECLARATION OF PURPOSE.— Congress finds that substantial numbers of pregnant, postpartum, and breastfeeding women, infants, and young children from families with inadequate income are at special risk with respect to their physical and mental health by reason of inadequate nutrition or health care, or both. It is, therefore, the purpose of the program [authorized] established by this section to provide[, up to the authorization levels set forth in subsection (g) of this section,], *up to the levels made available under this section*, supplemental foods and nutrition education through any eligible local agency that applies for participation in the program. The program shall serve as an adjunct to good health care, during critical times of growth and development, to prevent the occurrence of health care, during critical times of growth and development, to prevent the occurrence of health problems, including drug abuse, and improve the health status of these persons.

* * * * *

(c) GRANTS-IN-AID; CASH GRANTS; RATABLE REDUCTION OF AMOUNT AN AGENCY MAY DISTRIBUTE; AFFIRMATIVE ACTION; REGULATIONS RELATING TO DUAL RECEIPT OF BENEFITS UNDER COMMODITY SUPPLEMENTAL FOOD PROGRAM; STATE ELIGIBILITY FOR WIC FUNDS.—

(1) The Secretary [may] *shall* carry out a special supplemental food program to assist State agencies through grants-in-aid and other means to provide, through local agencies, at no cost, supplemental foods and nutrition education to low-income pregnant, postpartum, and breastfeeding women, infants and children who satisfy the eligibility requirements specified in subsection (d) of this section. The program shall be supplementary to—

(A) The food stamp program;

(B) Any program under which foods are distributed to needy families in lieu of food stamps; and

(C) Receipt of food or meals from soup kitchens, or shelters, or other forms of emergency food assistance.

(2) Subject to amounts [appropriated] *made available* to carry out this section under subsection (g) of this section—

* * * * *

(g) AUTHORIZATION OF APPROPRIATIONS; ALLOCATION OF FUNDS; ESTIMATE OF FAMILIES HAVING INCOME BELOW LIMIT FOR PARTICIPATION.—

[(1) There are authorized to be appropriated to carry out this section \$2,158,000,000 for the fiscal year 1990, and such sums as may be necessary for each of the fiscal years 1991, 1992, 1993, and 1994. As authorized by section 1752 of this title, appropriations to carry out the provisions of this section may be made not more than 1 year in advance of the beginning of the fiscal year in which the funds will become available for disbursement to the States, and shall remain available for the purposes for which appropriated until expended.]

(1)(A) *There are authorized to be—*

(i) appropriated to carry out this section such amounts as are necessary for each of fiscal years 1995 through 2000; and

(ii) made available such amounts as are necessary for the Secretary of the Treasury to fulfill the requirements of subparagraph (B).

(B)(i) Out of any money in the Treasury not otherwise appropriated, the Secretary of the Treasury shall provide to the Secretary of Agriculture, on January 1 of each fiscal year, to carry out this subsection—

(I) \$254,000,000 for fiscal year 1996;

(II) \$407,000,000 for fiscal year 1997;

(III) \$384,000,000 for fiscal year 1998;

(IV) \$398,000,000 for fiscal year 1999; and

(V) \$411,000,000 for fiscal year 2000.

(ii) The Secretary of Agriculture shall be entitled to receive the funds and shall accept the funds.

(C) In lieu of obligating the funds made available under subparagraph (B) to carry out this subsection, if the amount appropriated (in addition to the amount appropriated under subparagraph (B)(i)) to carry out this subsection for—

(i) fiscal year 1996 is less than \$3,660,000,000, the amount referred to in subparagraph (B)(i)(I) shall be obligated by the Secretary, during the period beginning December 31, 1995, and ending June 30, 1996, to increase the special assistance factor prescribed under section 11(a) of the National School Lunch Act (42 U.S.C. 1759a(a)) for free lunches served under the school lunch program (as established under section 4 of such Act (42 U.S.C. 1753));

(ii) fiscal year 1997 is less than \$3,759,000,000, the amount referred to in subparagraph (B)(i)(II) shall be obligated by the Secretary, during the period beginning December 31, 1996, and ending June 30, 1997, to increase the special assistance factor prescribed under section 11(a) of such Act for free lunches served under the school lunch program (as established under section 4 of such Act);

(iii) fiscal year 1998 is less than \$3,861,000,000, the amount referred to in subparagraph (B)(i)(III) shall be obligated by the Secretary, during the period beginning December 31, 1997, and ending June 30, 1998, to increase the special assistance factor prescribed under section 11(a) of such Act for free lunches served under the school lunch program (as established under section 4 of such Act);

(iv) fiscal year 1999 is less than \$3,996,000,000, the amount referred to in subparagraph (B)(i)(IV) shall be obligated by the Secretary, during the period beginning December 31, 1998, and ending June 30, 1999, to increase the special assistance factor prescribed under section 11(a) of such Act for free lunches served under the school lunch program (as established under section 4 of such Act); and

(v) fiscal year 2000 is less than \$4,136,000,000, the amount referred to in subparagraph (B)(i)(V) shall be obligated by the Secretary, during the period beginning December 31, 1999, and ending June 30, 2000, to increase the

special assistance factor prescribed under section 11(a) of such Act for free lunches served under the school lunch program (as established under section 4 of such Act);

(D) *Any increase in the special assistance factor prescribed under section 11(a) of such Act as a result of subparagraph (C) shall not affect any annual adjustment in the factor under section 11(a)(3) of such Act.*

* * * * *

(4) Of the sums [appropriated] *made available* for any fiscal year for programs authorized under this section, not less than nine-tenths of 1 percent shall be available first for services to eligible members of migrant populations. The migrant services shall be provided in a manner consistent with the priority system of a State for program participation.

(5) Of the sums [appropriated] *made available* for any fiscal year for the program under this section, one-half of 1 percent, not to exceed \$5,000,000, shall be available to the Secretary for the purpose of evaluating program performance, evaluating health benefits, preparing the report required under subsection (d)(4) of this section, providing technical assistance to improve State agency administrative systems, and administration of pilot projects, including projects designed to meet the special needs of migrants, Indians, and rural populations.

* * * * *

(h) FUNDS FOR NUTRITION SERVICES AND ADMINISTRATION.—

(1)(A) Each fiscal year, the Secretary shall make available, from amounts [appropriated] *made available* for such fiscal year under subsection (g)(1) of this section and amounts remaining from amounts [appropriated] *made available* under such subsection for the preceding fiscal year, an amount sufficient to guarantee a national average per participant grant to be allocated among State agencies for costs incurred by State and local agencies for nutrition services and administration for such year.

* * * * *

(C) In any fiscal year, amounts remaining from amounts [appropriated] *made available* for such fiscal year under subsection (g)(1) of this section and from amounts [appropriated] *made available* under such section for the preceding fiscal year, after carrying out subparagraph (A), shall be made available for food benefits under this section, except to the extent that such amounts are needed to carry out the purposes of subsections (g)(4) and (g)(5) of this section.

(2)(A) For each of the fiscal years [1990, 1991, 1992, 1993 and 1994] *1990 through 2000*, the Secretary shall allocate to each State agency from the amount described in paragraph (1)(A) an amount for costs of nutrition services and administration on the basis of a formula prescribed by the Secretary. Such formula shall—

* * * * *

(l) DONATION OF FOODS BY SECRETARY.—Foods available under section 1431 of Title 7, including, but not limited to, dry milk, or

purchased under section 612c of Title 7, may be donated by the Secretary, at the request of a State agency, for distribution to programs conducted under this section. The Secretary may purchase and distribute, at the request of a State agency, supplemental foods for donation to programs conducted under this section, with appropriated funds, including [funds appropriated] *funds made available* under this section.

DAVIS-BACON ACT

* * * * *

SEC. 276a. RATE OF WAGES FOR LABORERS AND MECHANICS.

(a) * * *

(b) As used in sections 276a to 276a-5 of this title the term "wages", "scale of wages", "wage rates", "minimum wages", and "prevailing wages" shall include—

- (1) the basic hourly rate of pay; and
- (2) the amount of—

(A) the rate of contribution irrevocably made by a contractor or subcontractor to a trustee or to a third person pursuant to a fund, plan, or program; and

(B) the rate of costs to the contractor or subcontractor which may be reasonably anticipated in providing benefits to laborers and mechanics pursuant to an enforceable commitment to carry out a financially responsible plan or program which was communicated in writing to the laborers and mechanics affected,

for medical or hospital care, pensions on retirement or death, compensation for injuries or illness resulting from occupational activity, or insurance to provide any of the foregoing, for unemployment benefits, life insurance, disability and sickness insurance, or accident insurance, for vacation and holiday pay, for defraying costs of apprenticeship or other similar programs, or for other bona fide fringe benefits, but only where the contractor or subcontractor is not required by other Federal, State, or local law (*other than benefits provided pursuant to the Health Security Act*) to provide any of such benefits:

* * * * *

SERVICE CONTRACT ACT

* * * * *

SEC. 351. REQUIRED CONTRACT PROVISIONS; MINIMUM WAGES.

(a) * * *

* * * * *

(2) A provision specifying the fringe benefits to be furnished the various classes of service employees, engaged in the performance of the contract or any subcontract thereunder, as determined by the Secretary or his authorized representative to be prevailing for such employees in the locality, or, where a collective-bargaining agreement covers any such service employees, to be provided for in such agreement, including pro-

spective fringe benefit increases provided for in such agreement as a result of arm's-length negotiations. Such fringe benefits shall include medical or hospital care, pensions on retirement or death, compensation for injuries or illness resulting from occupational activity, or insurance to provide any of the foregoing, unemployment benefits, life insurance, disability and sickness insurance, accident insurance, vacation and holiday pay, costs of apprenticeship or other similar programs and other bona fide fringe benefits not otherwise required by Federal, State, or local law (*other than benefits provided pursuant to the Health Security Act*) to be provided by the contractor or subcontractor. The obligation under this subparagraph may be discharged by furnishing any equivalent combinations of fringe benefits or by making equivalent or differential payments in cash under rules and regulations established by the Secretary.

* * * * *

HEALTH CARE QUALITY IMPROVEMENT ACT OF 1986

* * * * *

SEC. 427. [11137] MISCELLANEOUS PROVISIONS.

(a) PROVIDING LICENSING BOARDS AND OTHER HEALTH CARE RELATED ENTITIES WITH ACCESS TO INFORMATION.—The Secretary (or the agency designated under section 424(b)) shall, upon request, provide information reported under this part with respect to a physician or other licensed health care practitioner to State licensing boards, to sponsors of point-of-service networks under section 1990 of the Social Security Act, to hospitals, and to other health care entities (including health maintenance organizations) that have entered (or may be entering) into an employment or affiliation relationship with the physician or practitioner or to which the physician or practitioner has applied for clinical privileges or appointment to the medical staff. *Not later than January 1, 1996, the Secretary shall promulgate regulations under which individuals seeking to enroll in health plans under the Health Security Act shall be able to obtain information reported under this part with respect to physicians and other licensed health practitioners participating in such plans for whom information has been reported under this part on repeated occasions.*"

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TITLE 11—UNITED STATES CODE

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§ 507. Priorities

(a) The following expenses and claims have priority in the following order:

(1) * * *

* * * * *

[(8) Eighth, allowed unsecured claims based upon any commitment by the debtor to the Federal Deposit Insurance Corporation, the Resolution Trust Corporation, the Director of the Office of Thrift Supervision, the Comptroller of the Currency, or the Board of Governors of the Federal Reserve System, or their predecessors or successors, to maintain the capital of an insured depository institution.]

(8) *Eighth, allowed unsecured claims—*

(A) *based upon any commitment by the debtor to the Federal Deposit Insurance Corporation, the Resolution Trust Corporation, the Director of the Office of Thrift Supervision, the Comptroller of the Currency, or the Board of Governors of the Federal Reserve System, or their predecessors or successors, to maintain the capital of an insured depository institution;*

(B) *for payments under subtitle B of title IV of the Health Security Act owed to a State (as defined in section 1301 of such Act);*

(C) *for payments owed to an experienced-rated health plan under trusteeship of the Secretary of Labor under section 1395 of the Health Security Act; or*

(D) *for assessments and related amounts owed to the Secretary of Labor under section 1397 of the Health Security Act.*

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TITLE 15—UNITED STATES CODE

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SEC. 1013. **SUSPENSION UNTIL JUNE 30, 1948, OF APPLICATION OF CERTAIN FEDERAL LAWS; SHERMAN ANTITRUST ACT APPLICABLE TO AGREEMENTS TO, OR ACTS OF, BOYCOTT, COERCION, OR INTIMIDATION.**

(a) * * *

* * * * *

(c) *Notwithstanding that the business OF insurance is regulated by State law, nothing in this Act shall limit the applicability of the following Acts to the business of insurance to the extent that such business relates to the provision of health benefits:*

(1) *The Sherman Act (15 U.S.C. 1 et seq.).*

(2) *The Clayton Act (15 U.S.C. 12 et seq.).*

(3) *Federal Trade Commission Act (15 U.S.C. 41 et seq.).*

(4) *The Act of June 19, 1936 (49 Stat. 1526; 15 U.S.C. 21a et seq.), known as the Robinson-Patman Antidiscrimination Act.*

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TITLE 18—UNITED STATES CODE

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PART I.—CRIMES

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1755. <i>Wrongful disclosure of personally identifiable health care information.</i>	
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* * * * *	

CHAPTER 11—BRIBERY, GRAFT, AND CONFLICTS OF INTEREST**SEC. 201. BRIBERY OF PUBLIC OFFICIALS AND WITNESSES.**

* * * * *

SEC. 226. BRIBERY AND GRAFT IN CONNECTION WITH HEALTH CARE.**(a) Whoever—**

(1) *directly or indirectly, corruptly gives, offers, or promises anything of value to a health care official, or offers or promises*

a health care official to give anything of value to any other person, with intent—

(A) to influence any of the health care official's actions, decisions, or duties relating to a consumer purchasing cooperative or health plan;

(B) to influence such an official to commit or aid in the committing, or collude in or allow, any fraud, or make opportunity for the commission of any fraud, on a consumer purchasing cooperative or health plan; or

(C) to induce such an official to engage in any conduct in violation of the lawful duty of such official; or

(2) being a health care official, directly or indirectly, corruptly demands, seeks, receives, accepts, or agrees to accept anything of value personally or for any other person or entity, the giving of which violates paragraph (1) of this subsection; shall be fined under this title or imprisoned not more than 15 years, or both.

(b) Whoever, otherwise than as provided by law for the proper discharge of any duty, directly or indirectly gives, offers, or promises anything of value to a health care official, for or because of any of the health care official's actions, decisions, or duties relating to a consumer purchasing cooperative or health plan, shall be fined under this title or imprisoned not more than two years, or both.

(c) As used in this section—

(1) the term "health care official" means—

(A) an administrator, officer, trustee, fiduciary, custodian, counsel, agent, or employee of any consumer purchasing cooperative or health plan;

(B) an officer, counsel, agent, or employee, of an organization that provides services under contract to any consumer purchasing cooperative or health plan;

(C) an official or employee of a State agency having regulatory authority over any consumer purchasing cooperative or health plan;

(D) an officer, counsel, agent, or employee of a health care sponsor;

(2) the term "health care sponsor" means any individual or entity serving as the sponsor of a consumer purchasing cooperative or health plan for purposes of the Health Security Act, and includes the joint board of trustees or other similar body used by two or more employers to administer a consumer purchasing cooperative or health plan for purposes of such Act; and

(3) the terms "consumer purchasing cooperatives" and "health plan" have the meanings given those terms under title I of the Health Security Act.

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CHAPTER 31—EMBEZZLEMENT AND THEFT

SEC. 641. PUBLIC MONEY, PROPERTY OR RECORDS.

* * * * *

SEC. 668. THEFT OR EMBEZZLEMENT IN CONNECTION WITH HEALTH CARE.

(a) *Whoever embezzles, steals, willfully and unlawfully converts to the use of any person other than the rightful owner, or intentionally misapplies any of the moneys, securities, premiums, credits, property, or other assets of a consumer purchasing cooperative, health plan, or of any fund connected with such a cooperative or plan, shall be fined under this title or imprisoned not more than 10 years, or both.*

(b) *As used in this section, the terms "consumer purchasing cooperative" and "health plan" have the meanings given those terms in title I of the Health Security Act.*

CHAPTER 45—FOREIGN RELATIONS**SEC. 951. AGENTS OF FOREIGN GOVERNMENTS.**

* * * * *

SEC. 982. CRIMINAL FORFEITURE.

(a)(1) * * *

* * * * *

(6) *The court, in imposing sentence on a person convicted of a Federal health care offense (as defined in section 5402(d) of the Health Security Act), shall order such person to forfeit to the United States any property, real or personal, constituting or traceable to the gross proceeds obtained, directly or indirectly, as a result of the commission of the offense.*

* * * * *

CHAPTER 47—FRAUD AND FALSE STATEMENTS**SEC. 1001. STATEMENTS OR ENTRIES GENERALLY.**

* * * * *

SEC. 1033. FALSE STATEMENTS RELATING TO HEALTH CARE MATTERS.

(a) *Whoever, in any matter involving a consumer purchasing cooperative or health plan, knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious, or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry, shall be fined under this title or imprisoned not more than 5 years, or both.*

(b) *As used in this section, the terms "consumer purchasing cooperative" and "health plan" have the meanings given those terms under title I of the Health Security Act.*

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CHAPTER 63—MAIL FRAUD**SEC. 1341. FRAUDS AND SWINDLES.**

* * * * *

SEC. 1345. INJUNCTIONS AGAINST FRAUD.

(a)(1) If a person is—

(A) violating or about to violate this chapter or section 287, 371 (insofar as such violation involves a conspiracy to defraud the United States or any agency thereof), or 1001 of this title; [or]

(B) committing or about to commit a banking law violation (as defined in section 3322(d) of this title), or

(C) committing or about to commit a Federal health care offense (as defined in section 5402(d) of the Health Security Act); the Attorney General may commence a civil action in any Federal court to enjoin such violation.

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CHAPTER 63—MAIL FRAUD

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SEC. 1346. DEFINITION OF "SCHEME OR ARTIFICE TO DEFRAUD".

* * * * *

SEC. 1347. HEALTH CARE FRAUD.

(a) *Whoever knowingly executes, or attempts to execute, a scheme or artifice—*

(1) to defraud any consumer purchasing cooperative, health plan, or other person, in connection with the delivery of or payment for health care benefits, items, or services; or

(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any consumer purchasing cooperative, health plan, or person in connection with the delivery of or payment for health care benefits, items, or services; shall be fined under this title or imprisoned not more than 10 years, or both. If the violation results in serious bodily injury (as defined in section 1365 of this title) such person shall be imprisoned for life or any term of years.

(b) *As used in this section—*

(1) the terms "consumer purchasing cooperative" and "health plan" have the meanings given those terms in title I of the Health Security Act; and

(2) the term "health care" includes long-term care under title II of the Health Security Act.

* * * * *

CHAPTER 84—PRESIDENTIAL ASSASSINATION, KIDNAPPING, AND ASSAULT

* * * * *

CHAPTER 84A—PRIVACY OF PERSONALLY IDENTIFIABLE HEALTH CARE INFORMATION

SEC. 1755. WRONGFUL DISCLOSURE OF PROTECTED HEALTH INFORMATION.

(a) *DEFINITION.—The term "protected health information" shall have the meaning given such term under section 5163 of the Health Security Act.*

(b) *OFFENSE.—A person who knowingly—*

(1) obtains protected health information relating to an individual in violation of subpart C of the Health Care Privacy Protection Act; or

(2) discloses protected health information to another person in violation of subpart C of the Health Care Privacy Protection Act.

shall be punished as provided in subsection (c).

(c) **PENALTIES.**—A person who violates subsection (b) shall—

(1) be fined not more than \$50,000, imprisoned not more than 1 year, or both;

(2) if the offense is committed under false pretenses, be fined not more than \$100,000, imprisoned not more than 5 years or both; and

(3) if the offense is committed with intent to sell, transfer, or use protected health information for commercial advantage, personal gain, or malicious harm, fined not more than \$250,000, imprisoned not more than 10 years, or both.

SEC. 1756. MISUSE OF HEALTH SECURITY CARD OR UNIQUE IDENTIFIER.

A person who—

(1) requires the display of, requires the use of, or uses a health security card that is issued under the Health Security Act for any purpose other than obtaining or paying for health care; or

(2) requires the disclosure of, requires the use of, or uses a unique identifier number for any purpose that is not authorized by the National Health Board.

shall be fined not more than \$25,000, imprisoned not more than 2 years, or both.

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CHAPTER 215—GRAND JURY

SEC. 3321. NUMBER OF GRAND JURORS; SUMMONING ADDITIONAL JURORS.

* * * * *

SEC. 3322. DISCLOSURE OF CERTAIN MATTERS OCCURRING BEFORE GRAND JURY.

(a) * * *

* * * * *

(c) A person who is privy to grand jury information concerning a health law violation—

(1) received in the course of duty as an attorney for Government; or

(2) disclosed under rule 6(e)(3)(A)(ii) of the Federal Rules of Criminal Procedure;

may disclose that information to an attorney for the Government to use in any civil proceeding related to a Federal health care offense (as defined in section 5402(d) of the Health Security Act).

[(c)] (d) A person to whom matter has been disclosed under this section shall not use such matter other than for the purpose for which such disclosure was authorized.

[(d)] (e) As used in this section—

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TITLE 31—UNITED STATES CODE

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CHAPTER 37—CLAIMS

SEC. 3721. CLAIMS OF PERSONNEL OF AGENCIES AND THE DISTRICT OF COLUMBIA GOVERNMENT FOR PERSONAL PROPERTY DAMAGE OR LOSS.

* * * * *

SEC. 3729. FALSE CLAIMS.

(a) LIABILITY FOR CERTAIN ACTS.—Any person who—

(1) * * *

* * * * *

(7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government *or to a health plan*, is liable to the United States Government for a civil penalty of not less than \$5,000 and not more than \$10,000, plus 3 times the amount of damages which the Government *or health plan* sustains because of the act of that person, except that if the court finds that—

(A) the person committing the violation of this subsection furnished officials of the United States responsible for investigating false claims violations with all information known to such person about the violation within 30 days after the date on which the defendant first obtained the information;

(B) such person fully cooperated with any Government investigation of such violation; and

(C) at the time such person furnished the United States with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under this title with respect to such violation, and the person did not have actual knowledge of the existence of an investigation into such violation;

the court may assess not less than 2 times the amount of damages which the Government *or health plan* sustains because of the act of the person. A person violating this subsection shall also be liable to the United States Government for the costs of a civil action brought to recover any such penalty or damages.

(b) KNOWING AND KNOWINGLY DEFINED.—For purposes of this section, the terms “knowing” and “knowingly” mean that a person, with respect to information—

(1) has actual knowledge of the information;

(2) acts in deliberate ignorance of the truth or falsity of the information; or

(3) acts in reckless disregard of the truth or falsity of the information,

and no proof of specific intent to defraud is required.

(c) CLAIM DEFINED.—For purposes of this section, *the term “claim”* includes any request or demand, whether under a contract or otherwise, for money or property which is made to a contractor, grantee, or other recipient if the United States Government provides any portion of the money or property which is requested or demanded, or if the Government will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded. *The term also includes any request or demand, whether under contract or otherwise, for money or property which is made or presented to a health plan.*

(d) EXEMPTION FROM DISCLOSURE.—Any information furnished pursuant to subparagraphs (A) through (C) of subsection (a) shall be exempt from disclosure under section 552 of title 5.

(e) EXCLUSION.—This section does not apply to claims, records, or statements made under the Internal Revenue Code of 1954.

(f) HEALTH PLAN DEFINED.—*For purposes of this section, the term “health plan” has the meaning given such term under section 1400 of the Health Security Act.*

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